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of Transportation
**Federal Aviation
Administration**

Federal Aviation Regulations

Title 14 of
Code of Federal Regulations
Part 67
Medical Standards and Certification

This FAA publication of the basic Part 67, effective November 1, 1962, incorporates Amendments 67–1 through 67–17 with preambles.

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INTRODUCTORY NOTE

Part 67 is codified under Subchapter D, Airmen, of Title 14 of the Code of Federal Regulations.

This FAA publication of the basic Part 67, effective Novermber 1, 1962, incorporates Amendments 67–1 through 67–17.

Bold brackets **[[ ]]** throughout the regulation indicate the most recently changed or added material for that particular subpart. The amendment number and effective date of new material appear in bold brackets at the end of each affected section.

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Part 67—Medical Standards and Certification

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Adoption of Subchapter D

Adopted: August 6, 1962 **Effective: November 1, 1962**

This amendment adds Subchapter D ''Airmen'' to Chapter I of Title 14 of the Code of Federal Regulations. The amendment is a part of the program of the Federal Aviation Agency to recodify its regulatory material into a new series of regulations called the ''Federal Aviation Regulations'' to replace the present ''Civil Air Regulations'' and ''Regulations of the Administrator''.

During the life of the recodification project, Chapter I of Title 14 may contain more than one part bearing the same number. To differentiate between the two, the recodified parts, such as the ones in this subchapter, will be labeled ''[New]''. The label will of course be dropped at the completion of the project as all of the regulations will be new.

Subchapter D [New] was published as a notice of proposed rule making in the *Federal Register* on May 2, 1962 (27 FR 4175) and as Draft Release 62–20.

Some of the comments received recommended specific substantive changes to the regulations. Although some of the recommendations might, upon further study, appear to be meritorious, they cannot be adopted as a part of the recodification program. The purpose of the program is simply to streamline and clarify present regulatory language and to delete obsolete or redundant provisions. To attempt substantive changes in the recodification of these regulations (other than minor, relaxatory ones that are completely noncontroversial) would delay the project and would be contrary to the ground rules specified for it in the *Federal Register* on November 15, 1961 (26 FR 10698) and Draft Release 62–20. However, all comments of this nature will be preserved and considered in any later substantive revision of the affected parts.

Certain changes, not contained in Draft Release 62–20, reflect amendments, to the parts revised herein, that became effective after the Draft Release was published. Each of these amendments, when published, contained a statement that they would be included in the final draft of the recodified parts affected and, in addition, Draft Release 62–20, stated that such amendments would be included in the final draft of the revised subchapter. See amendments 20–15, 20–16, 20–17, 21–3, 22–13, 22–14, 24–4, and 24–5.

Draft Release 62–14, dated April 2, 1962, proposed certain amendments to provisions of part 20 of the Civil Air Regulations under which former military pilots may obtain private and commercial pilot certificates on the basis of military competence. The period for receiving comments on the proposal having closed on June 7, 1962, and no adverse comments having been received thereon, these amendments are incorporated into § 61.31 of the revised subchapter.

Other minor changes of a technical clarifying nature or relaxatory nature have been made. They are not substantive and do not impose any burden on regulated persons. For example, the unnecessary provision, contained in CAR 21.23, that an airline transport pilot must present his pilot certificate for inspection by any person, has been deleted in the light of other existing requirements that such a pilot must present his certificate for inspection upon the request of the Administrator, an authorized representative of the CAB, any State or local law enforcement officer, or any passenger.

Draft Release 62–27 dated June 8, 1962 (27 FR 5686) contained a notice of the revision of the procedural rules of the Federal Aviation Agency. The preamble to the release stated that the certification procedural rules in part 406 of the Regulations of the Administrator were being considered for transfer to the parts to which they specifically applied, insofar as they did not duplicate provisions already in those parts. For this reason, a new subpart B, relating to procedures for medical certificates, has been added to part 67 ''Medical Standards and Certification'' [New]. The subpart is a revision, without substantive changes, of medical certification provisions now in part 406.

Of the comments received on Draft Release 62–20, several suggested changes in style, format, or technical wording. These comments have been carefully considered and, where consistent with the style, format, and terminology of the recodification project, were adopted.

The definitions, abbreviations, and rules of construction contained in part 1 [New] of the Federal Aviation Regulations apply to the new Subchapter D.

Interested persons have been afforded an opportunity to participate in the making of this regulation, and due consideration has been given to all relevant matter presented. The Agency appreciates the cooperative spirit in which the public's comments were submitted.

In consideration of the foregoing Chapter I of Title 14 of the Code of Federal Regulations is amended effective November 1, 1962.

This amendment is made under the authority of sections 313(a), 314, 601, and 607 of the Federal Aviation Act of 1958 (49 U.S.C. 1354(a), 1355, 1421, and 1427).

Amendment 67–1

Cheating on Tests and Other Irregularities

Adopted: February 11, 1965 **Effective: March 20, 1965**

(Published in 30 FR 2195, February 18, 1965)

The purpose of these amendments is to prohibit cheating or certain other unauthorized conduct in connection with FAA written airman or ground instructor tests; fraudulent or intentionally false applications for airman, ground instructor, or medical certificates or ratings, or entries in logbooks, records, or reports required in connection with these certificates or ratings; and alteration, or fraudulent reproduction of these certificates or ratings. This action was proposed in Notice No. 64–20 (29 FR 4919) issued April 1, 1964. As proposed, it applies to not only the airman regulations but also the regulations covering medical certification and ground instructors.

A number of comments were received on Notice No. 64–20, most of them generally favorable to the proposed amendments. Three comments opposed as too harsh the provision that the commission of a prohibited act is a basis for suspending or revoking an existing certificate or rating held by the violator. A major purpose for this provision is the deterrent effect of the enunciation of a strong available penalty. Thus, the provision is especially significant with respect to a person who assists another in the violation, for example by taking a test for him. In such a case, it is no deterrent to the former (who usually is obtained because he already holds the certificate the latter is seeking) merely to warn him that the principal penalty for taking a test in behalf of another person is that he will not be eligible, for a year thereafter, for any airman, ground instructor, or medical certificate or rating, as the case may be. The most effective deterrent in this situation would be the possibility of loss of one or all of the certificates he already possesses.

The one-year ineligibility for a certificate or rating is automatic in the case of cheating or other unauthorized conduct in connection with written tests. However, as indicated by Notice No. 64–20, the fact that suspension and revocation of certificates or ratings are made available in these regulations does not mean they must be imposed in every case or automatically upon every violator. The same degree of discretion and the same criteria for the imposition of these sanctions will be exercised by the Agency officials responsible for taking enforcement action in this area as in all other areas where penalties are provided for violation of regulations. Furthermore, the sanctions made available by these amendments do not preclude the imposition, in case of violation, of civil penalties under section 901 of the Federal Aviation Act of 1958 (49 U.S.C. 1471), either alone or in conjunction with these sanctions.

Comments also were received urging that acts to be prohibited by these amendments should be done ‘‘knowingly,’’ or ‘‘willfully,’’ or ’’knowingly or willfully,’’ to incur the sanctions provided. It of course is not the design of these amendments to prohibit acts that might likely be committed inadvertently. Accordingly, these amendments make clear that intention is an element of those prohibited acts that otherwise might likely be committed inadvertently, namely, the removal of a written test, or a false statement on an application for a certificate or rating or in a logbook, record, or required report. Also, responsive to several comments and reflecting the original intention as to reproductions of certificates or ratings, the prohibition has been restated to refer to reproduction for fraudulent purpose. Furthermore, the reference in Notice No. 64–20 to authorization by the Administrator in this connection has been dropped in these amendments, since only fraudulent reproductions are prohibited, and since new documents are issued where appropriate, thus obviating any need for authorizing alterations.

Interested persons have been afforded an opportunity to participate in the making of these amendments, and due consideration has been given to all matter presented.

In consideration of the foregoing, part 67 of the Federal Aviation Regulations is amended effective March 20, 1965.

These amendments are made under the authority of sections, 313(a), 601, 602, and 607 of the Federal Aviation Act of 1958 (49 U.S.C. 1354, 1421, 1422, 1427).

Amendment 67–2

Special Medical Flight or Practical Test or Medical Evaluation for Special Issue of Medical Certificate

Adopted: September 14, 1965 **Effective: October 21, 1965**

(Published in 30 FR 12025, September 21, 1965)

The purpose of these amendments is to make clear that the Federal Air Surgeon has authority (1) to decide whether a special medical flight or practical test, or special medical evaluation, should be conducted or the applicant's operational experience considered under § 67.19 of part 67 of the Federal Aviation Regulations, and, if so, (2) to prescribe which of these procedures should be used, in the determination of whether a medical certificate should be issued to an applicant who does not meet the applicable medical standards of that part. This action was proposed in Notice 65–10 (30 FR 6188) issued April 23, 1965.

Ten comments were received on Notice 65–10. Six were favorable and three unfavorable to the proposed amendments, and one was nonresponsive. Two of the unfavorable comments expressed concern that the amended rule would vest too much increased authority in the Federal Air Surgeon. The language contained in the proposal merely clarified the provisions of the existing rules and did not vest any increased authority in the Federal Air Surgeon. In this connection, one of these comments also asserted there would be nothing to ensure equal treatment of all applicants with the same defect. It should be noted that the objective of § 67.19 is to provide for the issue of a medical certificate to an applicant who does not meet the medical standards as prescribed in part 67. In order to achieve that objective in the consideration of the various types of medical deficiencies involved, the Federal Air Surgeon must be given the discretion to conduct the type of test or other procedure that he believes appropriate to determine whether the applicant can properly perform his duties as an airman.

One of these two comments on the proposal further suggested that any rule finally adopted should provide that if the medical defect is static the applicant should be entitled to an opportunity to take a special medical flight test. If adopted, this not only would make mandatory resort to a special procedure in one type of situation, but it also would prescribe the particular special procedure to be used. As stated in the preamble of Notice 65–10, situations arise in which the Federal Air Surgeon may determine that the applicant could not satisfactorily show, by any of the available special procedures, ability to perform the duties of an airman certificate without endangering safety in air commerce. In such a case, the resort to any of these procedures would not be purposeful, and the Federal Air Surgeon should have authority under § 67.19 to refuse their use. Also as stated in that preamble, where the Federal Air Surgeon does prescribe special medical flight or practical testing or special medical evaluation under § 67.19, the selection of the particular procedure to be used, of those named, essentially is an element of his medical determination whether the applicant can properly perform his duties as an airman despite his physical deficiency. This selection should repose in the Federal Air Surgeon because of his special qualifications and facilities available to him to obtain and assess medical information about an applicant's total medical status. Accordingly, it would defeat the objective of § 67.19 to provide for automatic entitlement to a designated procedure in any particular type of situation.

One of the favorable comments would make mandatory the consideration by the Federal Air Surgeon of an applicant's operational experience under § 67.19. Conversely, another comment expressed the belief that the applicant's operational experience is not germane to the evaluation of an airman's physical qualifications to hold a medical certificate. The medical requirements of the former part 29 of the CARs were amended, many years ago, to permit an evaluation of the applicant's aeronautical experience regardless of the type of airman certificate or rating sought or held by the applicant. The Agency has pursued this policy as applied by the Federal Air Surgeon, and the last sentence of § 67.19(a)(1) of the proposal expressed the intent of the Agency to continue this policy. To limit the discretionary authority of the Federal Air Surgeon in those cases by prohibiting any consideration by him of the applicant's operational experience, or making such consideration mandatory in all cases, regardless of the type of deficiency involved, would like the adoption of the suggestion on static defects, also defeat the objective of § 67.19.

Interested persons have been afforded an opportunity to participate in the making of these amendments to § 67.19, and due consideration has been given to all matter presented.

These amendments also substitute the term ''Federal Air Surgeon'' for the term ''Civil Air Surgeon'' throughout part 67, to state the correct current title of this official of the Agency. They also change the numbering of § 67.15(e) to conform with the parallel provisions of §§ 67.13(e) and 67.17(e), in order to preclude the continuation of some current confusion and technical mistakes in referring to these provisions.

Since these latter two changes are purely editorial in nature, notice and public procedure thereon are unnecessary.

In consideration of the foregoing, part 67 of the Federal Aviation Regulations is amended effective October 21, 1965.

These amendments are made under the authority of sections 313(a), 314, 601, and 602 of the Federal Aviation Act of 1958 (49 U.S.C. 1354, 1355, 1421, 1422).

Amendment 67–3

Distant Visual Acuity: First- and Second-Class Medical Certificates

Adopted: November 16, 1965 **Effective: November 23, 1965**

(Published in 30 FR 14562, November 23, 1965)

The purpose of these amendments is to change the distant visual acuity requirement for an applicant for a first- or second-class medical certificate from at least 20/50 to 20/100 in each eye separately before correction. This action was proposed in Notice 65–22 (30 FR 11732) issued September 7, 1965. All comments received on the proposal were favorable.

The present standard in §§ 67.13(b)(1) and 67.15(b)(1) of part 67 of the Federal Aviation Regulations requires an applicant for a first- or second-class medical certificate, respectively, to have distant visual acuity of at least 20/50 in each eye separately, before correction to 20/20 or better with corrective glasses. As stated in the preamble of Notice 65–22, this standard has been in effect unchanged since 1938, despite later significant technological advances in design and performances of aircraft, and in the environment in which they are operated. Also, as stated in that preamble, applicants with uncorrected distant visual acuity less than specified in the present standard, except those with gross myopic conditions, generally have been allowed to show under § 67.19 whether they have been able to operate aircraft without endangering safety in air commerce despite the disqualification. If they have not had other major disturbances in visual functions, they almost invariably have been able to demonstrate favorably, and they have received special issue of medical certificates on an individual basis. This process has required special detailed evaluations of all aspects of their vision, and has been expensive to applicants, both in money expended for ophthalmological examinations, and in issuance delay time, and it also has entailed considerable time and effort on the part of the Agency.

Accordingly, the accompanying amendments accommodate the distant visual acuity standard for first- and second-class medical certificates to current conditions, and dispense with special testing that in the great majority of cases would result in the special issue of a certificate anyway, without adverse effect upon safety.

Interested persons have been afforded an opportunity to participate in the making of these amendments, and due consideration has been given to all matter presented.

Since these amendments are relaxatory in nature and impose no burden upon any person, good cause exists for making them effective on less than 30 days published notice.

In consideration of the foregoing, part 67 of the Federal Aviation Regulations is amended effective November 23, 1965.

These amendments are made under the authority of section 313(a), 601, and 602 of the Federal Aviation Act of 1958 (49 U.S.C. 1354, 1421, and 1422).

Amendment 67–4

Special Issue of Medical Certificates for Air Traffic Control Tower Operators

Adopted: March 25, 1966 **Effective: March 31, 1966**

(Published in 31 FR 5190, March 31, 1966)

The purpose of this amendment is to remove the limitations contained in § 67.19(d) of the Federal Aviation Regulations, relating to special issuance of a medical certificate, so far as those limitations relate to air traffic tower operators.

Medical certification is now required of all airmen who perform their duties aloft, such as pilots, navigators and flight engineers. Only one class of airmen that perform duties on the ground are required to hold medical certificates—air traffic controllers. Air traffic controllers must hold a second class medical certificate, the same as required of commercial pilots. Private and student pilots, for example, hold only need a third class medical certificate.

Obviously there are great differences in the ground and flight environments in which these different airmen function. A pilot often is alone in the air and must at all times possess not only the technical, but also the physical capacity to act. Even in multi-engine aircraft, where crewmembers perform more specialized duties, the sudden physical incapacity of one can affect the overall crew operation to the extent that aircraft safety is seriously endangered. In general, the air traffic controller is under close supervision with back-up personnel close at hand, capable of performing his functions in the event he is physically disabled. Physical disabilities that may be under the applicable medical standards of part 67 disqualifying to a flight airman may be tolerated under controlled conditions, in a ground based airman. With these considerations in mind, and with the initiation of the new medical program described below, it is now possible for the Agency to establish a system for issuing waivers, under those controlled conditions, for certain physical defects in ground airmen.

The Federal Aviation Agency has established a health program for applicants and holders of FAA air traffic control specialist field facility positions oriented to the particular job and functional requirements of an air traffic control operator. The program includes the use of diagnostic techniques not required for a second class medical examination under this part, and provides for professional referrals, consultations, and follow-up examinations as necessary. The program provides that full regard shall be given to the practical requirements of the position. If the employee can be utilized with safety, apparently disqualifying defects or diseases may be waived.

Paragraph 67.19(d) removes from the scope of a special issuance of a medical certificate certain disorders and diseases that are disqualifying without further consideration. In view of the thorough annual examination being required of each FAA air traffic control specialist by the Agency described above, and an evaluation of the physical standards required for air traffic control positions occupied by FAA employees, the Federal Air Surgeon is in a position to determine whether an employee's disease or defect would disqualify him for the position the employee applies for or holds. The comprehensive health program and a more flexible standard for physical disqualification will permit the Agency to utilize trained and experienced employees with no derogation of safety.

There are additionally a group of control tower operators, employed in military or privately operated control towers, who may benefit from the special issuance of medical certificates provided by this amendment. In view of the small number of persons involved, the Federal Air Surgeon can review the special issuance of these control tower operator medical certificates without an undue burden added.

Since this amendment is procedural in nature and results in providing all certificated air traffic control tower operators an additional benefit, notice and public procedure thereon are not required and this amendment may be made effective in less than 30 days after publication.

In consideration of the foregoing, section 67.19(d) is amended and effective March 31, 1966.

This amendment is made under the authority of sections 307, 313(a) and 602 of the Federal Aviation Act of 1958 (49 U.S.C. 1348, 1354, 1422).

Amendment 67–5

Delegations of Authority to Reconsider Certification Actions; Denials by Representatives of the Federal Air Surgeon Within FAA; and Failure to Furnish Additional Medical Information

Adopted: June 9, 1966 **Effective: July 16, 1966**

(Published in 31 FR 8355, June 15, 1966)

The purpose of these amendments to part 67 of the Federal Aviation Regulations is (1) to provide authorization for certain representatives of the Federal Air Surgeon within the Agency (the Chief, Aeromedical Certification Branch, Civil Aeromedical Institute, and Regional Flight Surgeons) to finally reconsider issuances and denials of medical certificates by aviation medical examiners, in certain situations; (2) to provide that a denial by such a representative in any of those situations is considered to be a denial by the Administrator for the purpose of review by the Civil Aeronautics Board; (3) to require the surrender, upon request, of a medical certificate whose issue is reversed, wholly or in part, upon

reconsideration by the Federal Air Surgeon or such a representative; and (4) to state in the regulations that if an applicant for, or holder of, a medical certificate refuses to furnish additional medical information the Administrator may suspend, modify, or revoke a certificate, or refuse to issue it. Except for the scope of the first and second items mentioned, that is now made narrower than originally contemplated, these amendments were proposed in Notice 65–41 issued December 16, 1965 (30 FR 16084), for which the comment period was extended to March 23, 1966 by Notice 65–41A issued February 2, 1966 (31 FR 1312).

A number of the comments received on Notice 65–41 concurred in the proposals made. One of these comments (as well as several others that did not concur) displayed apprehension that delegation of authority to representatives of the Federal Air Surgeon to ''finally reconsider'' actions of aviation medical examiners would eliminate an applicant's recourse to petition for exemption from the rules. This apprehension is not well grounded, for Notice 65–41 is not concerned with the exemption procedure in any respect, either explicitly or implicitly. Both the Notice and these amendments are concerned only with the administration of the rules in part 67, not with the grant or denial of exemptions issued in accordance with rules specifically provided in the rule-making procedures of part 11.

Some comments presented strong objections to the proposed delegation of authority to representatives of the Federal Air Surgeon within the Agency. One comment concurred in the proposal so far as it would apply to cases where the Federal Air Surgeon does not have authority in any event to consider special issue of medical certificates (cases excluded from (§ 67.19). It was asserted that the proposed amendments would improperly tend to shift the Federal Air Surgeon's authority to make important decisions in the medical certification area to Regional Flight Surgeons; abrogate the denial authority of the Federal Air Surgeon; and result in a lack of uniformity in the application of medical standards. The first and second assertions display needless apprehension, since the proposals would not affect the general policy making responsibility of the Federal Air Surgeon, and the delegation to his representatives would not deprive him of his own authority in the area.

The assertion that a lack of uniformity might result, in the application of medical standards in the certification process, has pointed out an item susceptible of controversy, with strong arguments on each side. As stated in Notice 65–41, the proposal was in keeping with the Agency's policy of decentralization, and would foster a lessening of the delays incident to geographic distances and needless duplication of activity. However, it is recognized that the assertion may have merit, in this highly specialized field of medicine where various individuals may conceivably have different interpretations of a given set of medical facts.

After careful consideration of all issues involved, the Agency has concluded that, in view of this argument against the proposed change, it is doubtful that the action would preserve the maintenance of uniformity in the application of medical standards, and its adoption in full is inappropriate at this time. Therefore, the Agency has dropped this proposed change so far as it pertains to cases in which the Federal Air Surgeon has authority under part 67 to override a denial of a medical certificate. However, in certain areas listed in § 67.19(d), the regulations do not allow the Federal Air Surgeon to issue medical certificates specially to applicants with established inability to meet the applicable medical standards. In these areas the Federal Air Surgeon has no alternative but to confirm the denial action of his representatives, although he of course provides guide-lines to aviation medical examiners for the application of the medical standards in all cases. The areas involve established medical history or clinical diagnosis of: (1) myocardial infarction, or angina pectoris or other evidence of coronary heart disease that the Federal Air Surgeon finds may reasonably be expected to lead to myocardial infarction; (2) a character or behavior disorder that is severe enough to have repeatedly manifested itself by overt acts, a psychotic disorder, chronic alcoholism, drug addiction, epilepsy, or a disturbance of consciousness without satisfactory medical explanation of the cause; and (3) diabetes mellitus that requires insulin or any other hypoglycemic drug for control. In 1964, approximately 919 and in 1965 approximately 962 cases were referred to the Federal Air Surgeon for further review. Of these, 350 cases in 1964 and 316 cases in 1965, or about one-third of all of the cases so referred. Involved denials of medical certificates in the areas described, and the Federal Air Surgeon routinely affirmed the denials, as required. The delegation of final Agency denial authority to representatives in these cases will spare the applicants, as well as the government, great expense and useless effort. These amendments therefore adopt the proposal made in Notice 65–41, to the extent indicated, and as a result greater and faster service will be provided to applicants. After an opportunity to evaluate operational experience under this limited delegation of authority, the Administrator may later delegate full authority to his representative at the Aeromedical Certification Branch, Oklahoma City, to finally reconsider all issuances and denials of medical certificates by aviation medical examiners.

It should be noted, in connection with this limited delegation of authority, that the Federal Air Surgeon and his representatives within the Agency not only retain authority to finally reconsider denials

of medical certificates except in the situations listed above, but also have authority upon their own initiative to reconsider issuances of medical certificates by aviation medical examiners. In this manner, cases involving novel or important features may be inquired into by the highest medical authority of the Agency, even where certificates have been issued, as contemplated by subsection 314(b) of the Federal Aviation Act of 1958.

One comment asserted that any attempt by the Agency to reverse the issue of a medical certificate by an aviation medical examiner, without compliance with section 609 of the Federal Aviation Act of 1958, would be invalid, as well undesirable. Several other comments also pointed out that the burden of proof is the Administrator's under section 609, whereas this burden is the applicant's under section 602 of the Act. Sub-section 314(b) of the Act empowers the Administrator to ''reconsider'' either the denial or issuance of a medical certificate by an aviation medical examiner. It is the Agency's position that when the Administrator exercises that power to correct an error committed by a private person in the exercise of delegated authority (where the aviation medical examiner should have taken a different course of action based upon the information available to him when he issued the medical certificate) the airman must rely upon his rights under section 602 of the Act if he is dissatisfied. In such a case, a ''reexamination'' under section 609 of the Act is not necessary. The position of the Agency is clarified in these amendments by adding a provision in § 67.25(b) that any action taken by the Federal Air Surgeon or his authorized representative within the Agency under subsection 314(b) of the Act that reverses, wholly or in part, the issue of a medical certificate by an aviation medical examiner is the denial of a certificate by the Administrator under section 602 of the Act.

The proposal to require surrender, upon request, of a medical certificate whose issue is reversed or otherwise changed, upon reconsideration, was generally supported by the comments received. Two comments expressed concern that this would permit arbitrary deprival of a certificate legally issue. However, as stated in Notice 65–41, the obligation is imposed with respect to a certificate that has been found to have been issued to an applicant who in fact does not meet the applicable standards, and the Agency considers this a reasonable requirement in order to protect against the use of the certificate.

In each of these reconsideration provisions, the action taken by the Federal Air Surgeon or his representative within the Agency is described as one to ''wholly or partly reverse'' the issue of the medical certificate. This language is used in order to make clear that the provisions concern action taken that is adverse to the applicant. It would be clearly unreasonable to provide that action taken upon reconsideration that is advantageous to the applicant is the denial of a medical certificate.

Most of the comments received were not opposed to the proposal to require the applicant or certificate holder to furnish additional medical information. Some comments asserted this authority could be exercised improperly to delve into irrelevant matters. However, as is plain from the provision, the purpose is to obtain additional medical information needed to determine whether an applicant is eligible to hold a medical certificate.

Interested persons have been afforded an opportunity to participate in the making of these amendments, and due consideration has been given to all relevant matter presented.

In consideration of the foregoing, and for the reasons stated in Notice 65–41, part 67 of the Federal Aviation Regulations is amended effective July 16, 1966.

These amendments are made under the authority of sections 303(d), 313(a), 314(b), 601, 602, and 609 of the Federal Aviation Act of 1958 (49 U.S.C. 1344, 1354, 1355(b), 1421, 1422, 1429).

Amendment 67–6

Special Issue of Medical Certificates by Chief, Aeromedical Certification Branch, and Regional Flight Surgeons

Adopted: June 17, 1968 **Effective: June 22, 1968**

(Published in 33 FR 9253, June 22, 1968)

The purpose of this amendment to part 67 of the Federal Aviation Regulations is to disclose for the guidance of the public the officials making the determinations required under § 67.19 for the issue of a medical certificate to an applicant who does not meet the applicable medical standards.

Section 67.19 provides for the issue of a medical certificate of the appropriate class to an applicant who does not meet the medical standards of part 67 (other than certain specified requirements). Under

the provisions of that section the Federal Air Surgeon determines whether special medical testing or evaluation should be conducted to issue a medical certificate with appropriate limitations to an applicant. This amendment shows that the Chief, Aeromedical Certification Branch, Civil Aeromedical Institute, and Regional Flight Surgeons will now have the same authority.

Since this amendment is procedural in nature, notice and public procedure thereon are not required and it may be made effective in less than 30 days after publication.

In consideration of the foregoing, § 67.19 of the Federal Aviation Regulations is amended effective June 22, 1968.

This amendment is made under the authority of sections 303(d), 313(a), 601, and 602 of the Federal Aviation Act of 1958 (49 U.S.C. 1344, 1354, 1421, 1422).

Amendment 67–7

Reconsideration of Certification Actions

Adopted: January 2, 1969 **Effective: February 8, 1969**

(Published in 34 FR 248, January 8, 1969)

The purpose of this amendment to part 67 of the Federal Aviation Regulations is to provide that certain FAA officials may on their own initiative reverse the issuance of a medical certificate by an aviation medical examiner, within 60 days after receiving additional medical information establishing the noneligibility of the holder of that certificate, when that information was requested within 60 days of issuance.

This amendment was proposed in Notice 68–14, and published in the *Federal Register* on July 10, 1968 (38 FR 9005).

Four public comments were received on the Notice, three of which concurred in the proposal or offered no objections. One comment objected to the proposal, asserting that it would be unfair to keep the airman in a state of suspense for any longer period of time because of FAA ''inefficiencies''. However, this comment failed to recognize that in many cases the need for more time stems from delays of the airman in providing needed medical information to establish his eligibility or noneligibility for a medical certificate. As stated in the Notice, § 67.25(b), as amended by Amendment 67–5, effective July 16, 1966, contains a 60-day time limitation within which FAA officials may reconsider and reverse the issuance of a medical certificate by an aviation medical examiner. However, although the reconsideration may indicate the need for additional medical information to determine whether an error was made by an aviation medical examiner, the authority of the FAA official to fully reconsider the case and reverse the issuance of the certificate, if necessary, could be effectively defeated by the failure (or delay) of the holder of the medical certificate to respond to the request for additional medical information within 60 days from the date the certificate was issued. This could allow operation of aircraft by airmen whose physical qualifications have not been fully determined, and, if necessary, require resort to action under section 609 of the Federal Aviation Act to prevent the airman from further operation of an aircraft until a determination can be made that he can do so safely.

Since the term ''medical information'' as used in § 67.31—Medical Records (under which information is requested) includes the results of ''medical testing'', the latter term is not used in the amended rule although it was used in the Notice. Also, the amendatory language has been rearranged for the purpose of clarification, but without change in meaning.

In consideration of the foregoing, part 67 of the Federal Aviation Regulations is amended effective February 8, 1969.

This amendment is issued under the authority of sections 303(d), 313(a), 601, and 602 of the Federal Aviation Act of 1958 (49 U.S.C. 1344, 1354(a), 1421, 1422) and of section 6(c) of the Department of Transportation Act (49 U.S.C. 1655(c)).

Amendment 67–8

Changes in References to FAA Regulations, Position Title, and Certain Addresses

Adopted: August 27, 1970 **Effective: September 4, 1970**

(Published in 35 FR 14074, September 4, 1970)

The purpose of these amendments to parts 61, 63, 65, 67, 141, and 143 of the Federal Aviation Regulations is to reflect in parts 65 and 141 appropriate references to part 430 of the Regulations of the National Transportation Safety Board; reflect in part 67 an organizational change in the title of the FAA Assistant Administrator to FAA Regional Director; and update several references in the Regulations to the addresses to which applications for replacement of lost or destroyed certificates and certain other communications with the FAA are sent. These amendments also correct an inadvertent error made in a recent amendment to part 65.

On April 1, 1967, the aviation safety functions of the Civil Aeronautics Board under Titles VI and VII of the Federal Aviation Act of 1958 were transferred to the National Transportation Safety Board (49 U.S.C. 1651 *et seq.*). Thereafter the Board issued part 430 of its Regulations pertaining to aircraft accidents, incidents, overdue aircraft, and safety investigations, effective November 10, 1969 (34 FR 15749). These amendments accordingly change the references in parts 65 and 141 to part 430 of the Regulations of the National Transportation Safety Board instead of to part 320 of the Regulations of the Civil Aeronautics Board.

The organizational title of FAA Assistant Administrator has been changed to FAA Regional Director, and this change is reflected in the amendments to part 67.

The addition of ''Department of Transportation'' and box numbers and zip codes to addresses found in parts 61, 63, 65, 67, and 143 serve to clarify and modernize mailing addresses to which applications for lost or destroyed certificates and certain other communications with the FAA are sent.

In Notice 70–12 (35 FR 4862) it was proposed that an air traffic control operator should not be authorized to issue air traffic control clearances for IFR flight without authorization from the appropriate air route traffic control center. In issuing Amendment 65–15 pursuant thereto (35 FR 12326) it was stated that a tower may be under the jurisdiction of some facility other than an air route traffic control center, and that therefore the general phrase of reference ''facility exercising IFR control'' would be used. However, in the amended § 65.45(b) the phrase ''air traffic control'' was inadvertently used instead of ''IFR control.'' These amendments correct that inadvertence by replacing ''air traffic control'' with ''IFR control.''

Notice and public procedure hereon are not required since these amendments merely reflect changes of law and procedures as well as the correction of an inadvertent clerical error, and they may therefore be made effective in less than 30 days.

In consideration of the foregoing, parts 61, 63, 65, 67, 141 and 143 of the Federal Aviation Regulations are amended effective September 4, 1970.

(Sections 313(a), 602, 608 of the Federal Aviation Act of 1958; 49 U.S.C. 1354(a), 1422, 1428. Section 6(c) of the Department of Transportation Act; 49 U.S.C. 1655(c)).

NOTE: Corrections to position title in section 67.23(a) and (b) are incorporated in the original printing of this basic volume.

Amendment 67–9

Revised Terminology and Separation of Disqualifying Mental and Neurologic Conditions

Adopted: February 14, 1972 **Effective: April 26, 1972**

(Published in 37 FR 4071, February 26, 1972)

The purpose of these amendments to part 67 of the Federal Aviation Regulations is (1) to revise the terminology used to denote mental and neurologic conditions that disqualify applicants for medical certificate, to conform with current usage in the medical profession: and (2) to separate what have been termed ''nervous system'' conditions into mental and neurologic disorders as two distinct groups of disqualifying conditions.

Interested persons have been afforded an opportunity to participate in the making of these amendments by a notice of proposed rule making (Notice 71–30) issued on September 28, 1971, and published in the *Federal Register* on October 5, 1971 (36 FR 19396). Due consideration has been given to all comments presented in response to that Notice.

Two public comments were received in response to the Notice. Each was from an aviation trade association, and each concurred in the proposed amendments.

As stated in the Notice, a disparity has existed between the terminology used in the standards involving mental disorders and currently accepted psychiatric terminology. As a result, difficulty has existed in applying the latter terminology to these mental disabilities although the basic definitions have remained essentially unchanged. To avoid the recurrence of these difficulties, particularly in enforcement actions, and to update the regulations, these amendments revise the terminology describing the mental requirements, as proposed in the Notice, to conform with the terminology generally used by specialists in that branch of medicine as contained in the Manual published by the American Psychiatric Association, ''Diagnostic and Statistical Manual of Mental Disorders (second edition 1968).'' It is intended that use of that terminology will reduce confusion and ambiguity in the use and application of psychiatric terms by enumerating and defining disqualifying mental disorders in conformity with the terminology used in the current practice of psychiatry.

The proposed changes were reviewed and approved by a committee of the American Psychiatric Association, and that committee indicated that the changes may be considered essentially semantic.

Additionally, as proposed, these amendments separate ''mental condition'' and ''neurologic condition'' under the appropriate sections of part 67 to clarify the applicable standards, as well as to recognize a division in professional specialization in disorders of a mental or neurologic nature. It is anticipated that this separation will also facilitate the gathering and analysis of statistical information relating to airman applicants who have been issued or denied medical certificates where mental or neurologic histories or conditions are concerned. As the neurologic terminology previously used in acceptable, no change is made in the enumeration of disqualifying neurologic disorders.

In consideration of the foregoing, part 67 of the Federal Aviation Regulations is amended effective April 26, 1972.

(Sections 313(a), 601, and 602 of the Federal Aviation Act of 1958; 49 U.S.C. 1354(a), 1421, 1422. Section 6(c) of the Department of Transportation Act; 49 U.S.C. 1655(c)).

Amendment 67–10

Visual Acuity Requirements for Medical Certificates; Use of Contact Lenses

Adopted: October 12, 1976 **Effective: December 21, 1976**

(Published in 41 FR 46432, October 21, 1976)

The purpose of this amendment to part 67 of the Federal Aviation Regulations is to permit the use of contact lenses (as well as eye glasses) to satisfy the distant visual acuity requirement of part 67.

Interested persons have been afforded an opportunity to participate in the making of this amendment by a Notice of Proposed Rulemaking (Notice No. 75–33) issued on September 2, 1975, and published in the *Federal Register* on September 10, 1975, (40 FR 42024). Due consideration has been given to all comments received in response to that Notice.

Notice No. 75–33 was issued in response to a petition for rulemaking submitted by the Aircraft Owners and Pilots Association (AOPA) by letter dated March 8, 1974. AOPA petitioned for amendment of the medical standards of part 67, specifically to authorize the use of contact lenses for meeting visual requirements for all classes of airman medical certificates. In support of its petition, AOPA contented that experience shows that the use of contact lenses produces no sudden unpredictable hazards to flight, and that once in place, a contact lens is not easily dislodged. AOPA also pointed out that in some situations contact lenses are superior to glasses because they do not obstruct the peripheral visual field as do spectacle frames, and further that contact-lens use in more compatible with the wearing of certain protective equipment.

The FAA has recognized the increasing popularity and use of contact lenses in the United States, and certain advantages of these lenses over spectacles. While the medical standards of part 67 of the

Federal Aviation Regulations specifically provide that acceptable vision correction shall be achieved through the use of glasses, Statements of Demonstrated Ability (special issuances) have been issued to applicants pursuant to § 67.19 of the Federal Aviation Regulations, permitting the use of contact lenses to correct distant visual acuity. Contact lenses that correct near visual acuity have not been considered acceptable for aviation duties. To date, these special issuances have been granted only upon submission of detailed reports by eye specialists and after review of these reports by FAA medical personnel. This administrative procedure has frequently delayed the initial medical certification of applicants who wish to wear contact lenses to meet distant visual acuity standards.

As pointed out in Notice 75–33, FAA experience indicates that, these evaluation reports have had limited value in uncovering significant pathology or evidence of complications that would contradict the use of contact lenses in the performance of aviation duties. In addition, the agency is unaware of any accidents or incidents in which the use of contact lenses by airmen was a contributing factor.

One hundred thirty-seven comments were received in response to this proposal. Most of the comments received were favorable, five expressed no opinion, and one opposed the proposed amendment. The comment in opposition to the proposal stated that the possibility of dislodgement of lenses might adversely affect safety.

Several commentators suggested that contact lens wearers be required to carry ''backup'' glasses to replace their contact lenses in the event the lenses are dislodged during operation of an aircraft.

In developing Notice No. 75–33 the FAA considered requiring contact lens wearers to carry an extra pair of contact lenses or glasses while performing airman duties. The FAA concluded, however, that the likelihood of losing one or both lenses during flight was not of sufficient magnitude to warrant such a requirement. Moreover, it was noted that should an individual lose one lens and attempt to improve vision with ''backup'' glasses, he would most likely have to remove the remaining lens and that under any circumstances, corneal molding from the lens would not permit full interchange of lenses and glasses. Furthermore, if a lens was lost during a critical phase of flight, there would be no opportunity to replace the lens with a ''backup'' contact lens and the airman might be better off under those circumstances with only one lens in place.

The FAA has determined that the question of whether the airman should routinely carry a spare set of lenses (contact lenses or glasses), may be left to the individual without adversely affecting aviation safety. It should be noted that present regulations do not require ''backup'' glasses when glasses are needed to meet the visual acuity standards, even though glasses may be misplaced or dropped, just as with contact lenses. There has been no indication that the absence of such a requirement has in any way compromised safety.

Additionally, several commentators stated that effects of corneal molding from wearing contact lenses may create difficulties in assessing an applicant's uncorrected distant visual acuity at the time of examination. The commentators pointed out that such circumstances could interfere with the appropriate application of existing visual acuity standards that require applicants for first- and second-class medical certificates to have distant visual acuity of at least 20/100 in each eye separately, without correction.

The FAA believes that this potential problem does not require regulatory action at this time. Designated Aviation Medical Examiners will be provided guidelines for the evaluation and testing of applicants who wear contact lenses.

An applicant whose uncorrected visual actuity is substantially affected by recent use of contact lenses will be advised not to wear the lenses for a period of time and then will be re-examined.

The FAA believes that the use of contact lenses to correct distant visual acuity will not adversely affect safety, and that the administrative delay experienced by applicants by obtaining special issuances under § 67.19 will be avoided by amending part 67 to permit the use of contact lenses as well as eye glasses.

These amendments are made under the authority of sections 313(a), 601 and 602 of the Federal Aviation Act of 1958 (49 U.S.C. 1354, 1421, and 1422) and section 6(c) of the Department of Transportation Act (49 U.S.C. 1655(c)).

In consideration of the foregoing, §§ 67.13(b)(1), 67.15(b)(1) and 67.17(b)(1) of part 67 of the Federal Aviation Regulations are amended effective December 21, 1976.

Amendment 67–11

Special Issuance of Airman Medical Certificates and Revision of Cardiovascular and Alcoholism Standards

Adopted: February 8, 1982 **Effective: May 17, 1982**

(Published in 47 FR 16298, April 15, 1982)

SUMMARY: This amendment revises the special discretionary procedures for issuing airman medical certificates to persons who do not qualify for certification under §§ 67.13, 67.15, or 67.17 of the Federal Aviation Regulations. These procedures will now be available to individuals with certain medical conditions who previously had to seek a formal exemption from the regulations. It makes available a simpler administrative procedure that is expected to reduce the time applicants must wait for a decision. The revised rule also emphasizes that in making medical certification decisions for these individuals the FAA considers the right of the private pilot to accept greater risk to self than the commercial or airline transport pilot may accept, as long as safety for others in air commerce is not endangered.

In compliance with Executive Order 12291, Federal Regulation, the FAA intends to conduct a complete review of the FAA's medical standards. In the interim, this amendment also clarifies the medical standards in §§ 67.13, 67.15, and 67.17 for applicants with a medical history or clinical diagnosis of heart disease. Although the pending review of all the medical standards in part 67 could result in significant changes to that part, this interim clarification is needed to eliminate confusion about the standards that has resulted in quasijudicial decisions directing the certification of individuals who are subject to the incapacitating health effects of heart disease. These decisions have required issuance of certificates without the monitoring which is needed to assess risk to the safe operation of aircraft and to other persons in the air and on the ground. Individuals who are disqualified under these standards may be certificated, where appropriate, through the discretionary special issuance procedures by which adequate monitoring and other appropriate limitations may be imposed.

The amendment also revises the standard for the certification of individuals with a medical history or clinical diagnosis of alcoholism, to qualify individuals who provide evidence of adequately restored health. This relief has previously been granted only through the formal exemption process.

FOR FURTHER INFORMATION CONTACT: William H. Hark, M.D., Aeromedical Standards Division, Office of Aviation Medicine, Associate Administrator for Aviation Standards, 800 Independence Avenue, SW., Washington, DC 20591; telephone (202) 426–3802.

SUPPLEMENTARY INFORMATION:

On December 1, 1980, the FAA issued Notice of Proposed Rulemaking No. 80–24 (45 FR 80296; December 4, 1980), proposing to articulate in part 67 the exemption procedures for issuing airman medical certificates to persons who do not qualify for certification under the medical standards in §§ 67.13, 67.15, or 67.17. Notice 80–24 also proposed to revise the medical standard for applicants with a medical history or clinical diagnosis of heart disease. A public hearing on this Notice was held on February 3 and 4, 1981. All interested persons have been given an opportunity to participate in the making of the proposed regulations, and due consideration has been given to all matters presented.

Summary

After consideration of all the comments received in response to Notice 80–24 and presented at the public hearing, the FAA has taken the following actions in adopting this final rule:

1. In accordance with Executive Order 12291, Federal Regulation, the FAA has decided that it should undertake an overall review of the medical standards in part 67 of the Federal Aviation Regulations. This total and comprehensive review will be a major rulemaking effort to obtain the views of the medical profession and all interested parties, and could result in significant revision of part 67.

2. To improve the responsiveness of the medical certification system, the special issuance procedures in § 67.19 are being amended to apply them to all medical conditions, including those for which relief was previously granted only by exemption. The exemption procedures proposed in Notice 80–4 are not being added to part 67 since the practice of granting relief through these procedures will be discontinued. This procedural reform is expected to decrease the time an applicant must wait for a decision on certification by reducing the administrative burden on the FAA.

3. To expedite access to the National Transportation Safety Board (NTSB), in many cases, this final rule revises § 67.25 to increase the instances in which the denial of a certificate by an official other than the Federal Air Surgeon may be considered the final decision by the Administrator that is necessary before the applicant can appeal to the NTSB. (This will not, however, preclude a request for further consideration by the Federal Air Surgeon, in consultation with appropriate medical specialists, should the applicant so desire.)

4. To make it possible for certain airmen to perform activities that can be safely performed with their specific physical capabilities and overall medical condition, this final rule delegates authority to place functional limitations on medical certificates issued under § 67.19 to the Federal Air Surgeon, in coordination with the Director of Flight Operations. The rule limits their use to second- and third-class medical certificates, without prejudicing those individuals already holding first-class certificates with functional limitations.

5. To state clearly the FAA's policy, § 67.19 is being amended to state that, in granting discretionary special issuances to applicants for private pilot certificates, the Federal Air Surgeon considers the freedom of these applicants to accept reasonable risks to their person and property that are not acceptable in the exercise of commercial or airline transport privileges, and, at the same time, considers the need to protect the public safety of persons and property in other aircraft and on the ground.

6. To eliminate confusion over the meaning of the cardiovascular standards in §§ 67.13(e)(1), 67.15(e)(1), and 67.17(e)(1) and thus avoid the possibility of unrestricted certification of individuals who do not meet those standards, the FAA is adopting an interim clarification of those provisions. Notwithstanding their clarification at this time, the cardiovascular standards, along with all other medical standards, will be made the subject of the overall review of part 67.

7. To ensure that the alcoholism standard in part 67 clearly conforms to the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, the applicable provisions are being revised. The standard itself will not provide for certification of individuals who submit clinical evidence of recovery, including, among other things, a 2-year period of sustained abstinence. This will provide relief in the certification standard itself to many individuals who in the past could seek certification only through the exemption process.

Background

Medical Certification of Airmen

Part 67 of the Federal Aviation Regulations (14 CFR part 67) provides for the issuance of three classes of medical certificates. A first-class medical certificate is required to exercise the privileges of an airline transport pilot certificate. Second- and third-class medical certificates are needed for commercial and private pilot certificates, respectively.

An applicant who is found to meet the appropriate medical standards, based on a medical examination and an evaluation of the applicant's history and condition, is entitled to a medical certificate without restrictions or limitations other than the prescribed limits as to its duration. These medical standards are set forth in §§ 67.13, 67.15, and 67.17 (14 CFR §§ 67.13, 67.15, and 67.17).

An applicant for a medical certificate who is unable to meet the standards in §§ 67.13, 67.15, or 67.17 may nevertheless be issued an appropriate medical certificate under one of two procedures. These procedures have always been available, and, thus, these standards have never been ''absolutely disqualifying,'' in the sense that certification was permanently denied all who did not meet the standards.

Under § 67.19, ''Special issue: operational limitations,'' at the discretion of the Federal Air Surgeon, acting on behalf of the Administrator under § 67.25, a special flight test, practical test, or medical evaluation may be conducted to determine that, notwithstanding the applicant's failure to meet the applicable medical standard, airman duties can be performed, with appropriate limitations or conditions, without endangering safety in air commerce. If this determination can be made, a medical certificate may be issued with appropriate limitations to ensure safety.

Prior to this amendment, however, applicants with certain medical conditions could not use the special issuance procedures in § 67.19. That section has not allowed a special issuance of a medical certificate to applicants with an established medical history or clinical diagnosis of any of the following: (1) A personality disorder severe enough to have repeatedly manifested itself by overt acts; (2) a psychosis; (3) alcoholism; (4) drug dependence; (5) epilepsy; (6) a disturbance of consciousness without satisfactory medical explanation of the cause; (7) myocardial infarction; (8) angina pectoris or other evidence of coronary heart disease that the Federal Air Surgeon finds may reasonably be expected to lead to myocardial

infarction; or (9) diabetes mellitus that requires insulin or another hypoglycemic drug for control. (The one exception to this policy has been for air traffic control tower operators.)

The second procedure open to an applicant denied certification under §§ 67.13, 67.15, or 67.17 (and the only one previously available to those with conditions excluded from § 67.19) has been to petition for a formal exemption from the specific medical standard he or she had failed to meet, in accordance with § 11.25, ''Petitions for rulemaking and exemptions'' (14 CFR 11.25). If the relief requested was in the public interest and provided a level of safety equivalent to that provided by the standard, an exemption was issued authorizing an appropriate medical certificate.

Proposed Amendment

Notice 80–24 proposed specific exemption procedures for part 67. They were proposed in response to a Federal District Court decision in the case of *Delta Air Lines, Inc.,* v. *United States, et al.,* 490 F. Supp. 907 (N.D. Ga. 1980) (*Delta* case). In that case Delta Air Lines challenged the authority of the Federal Air Surgeon to place certain limitations on airman medical certificates issued under the authority of exemptions from part 67 and questioned the propriety of issuing exemptions at all under the current regulatory structure of part 67.

In its decision the Court found that the Federal Air Surgeon, in granting exemptions from part 67, had acted improperly in placing functional limitations on the medical certificates issued under the authority of exemptions as well as those issued under § 67.19. These functional limitations (such as ''not valid for pilot-in-command duties'') restrict the position which an airman can hold in the cockpit. The Court found that the Federal Air Surgeon had not been delegated authority to impose these limitations.

The Court distinguished these limitations from operational limitations which, the Court found, are properly placed on medical certificates. They relate to procedures by which the applicant can be enabled to perform his or her duties (such as ''pilot must wear corrective lenses'' or, for pilots with defective color vision, ''not valid for night flight or by color signal control'').

Secondly, the Court found that in issuing exemptions from the nine areas excepted from the special issuance procedures in § 67.19, the FAA had effectively amended part 67. Although the FAA's evolving procedures were based on the advance of medical technology, the Court determined this change in policy had not been adopted in accordance with the Administrative Procedure Act.

While Notice 80–24 proposed explicit exemption procedures for part 67 with special emphasis on the nine areas excluded from § 67.19, the FAA has now determined that it should not continue to use the formal exemption process to grant relief to individuals who do not meet the medical standards for certification in §§ 67.13, 67.15, and 67.17. Instead, this relief can be provided more efficiently through the special issuance procedures and, to facilitate this, the nine exclusions are being deleted from § 67.19.

Exemption Process

A complex administrative procedure is involved in processing a formal petition for exemption from the medical standards of the Federal Aviation Regulations. It requires the preparation of extensive and detailed documents, the establishment of a public docket, and action by the Federal Air Surgeon and the Chief Counsel, on behalf of the Administrator. It creates an additional burden for the FAA and the airman seeking relief from disqualification under the medical standards. Moreover, as medical evaluation and treatment techniques have improved, increasing numbers of airmen with serious conditions have sought, and been granted, medical certification through the exemption process as the only avenue of relief available. The resulting increases in administrative processing time inconvenience petitioners, and the additional expenditure of FAA resources is significant. Numerous comments to Notice 80–24 indicate dissatisfaction with this system.

Special Issuance Procedures

The FAA's experience indicates that the medical certification of airmen with a history of serious illness is no longer unusual. It has determined that evaluation utilizing a broad range of medical expertise can be obtained through the more routine procedures for a special issuance under § 67.19, thereby reducing administrative delays and costs. By removing the nine exclusions from this section, any airman found to have a specifically disqualifying condition under the medical standards of part 67 may request an evaluation by the Federal Air Surgeon; the Chief, Aeromedical Certification Branch, Civil Aeromedical Institute; or a Regional Flight Surgeon for the special issuance of a medical certificate under § 67.19.

Years of experience with the special issuance of medical certificates in cases other than the nine excluded conditions indicate that extension of the authority to the Chief, Aeromedical Certification Branch,

Civil Aeromedical Institute, and the Regional Flight Surgeons to include those specified conditions will not impact adversely on airmen or on the safety of the certification process.

When a medical condition previously excluded from § 67.19 is involved, factors that will generally be considered in determining whether such an issuance is appropriate are, with some revision, those proposed in Notice 80–24 for consideration under exemption procedures. They are discussed later in this preamble.

Thus, by reducing the administrative delays of the exemption process and by decentralizing the decision authority in cases of specifically disqualifying conditions, significant improvements in system responsiveness and efficiency are possible.

Final Denial of Medical Certificates

Section 67.25 is being revised to give the Chief of the Aeromedical Certification Branch of the Civil Aeromedical Institute and the Regional Flight Surgeons additional authority to issue denials of medical certificates that are ''final'' for the purposes of appeal to the NTSB. Previously, the authority to issue a denial under section 602 of the Federal Aviation Act of 1958 (49 U.S.C. 1422), i.e., a ''denial by the Administrator,'' had been delegated only in the case of the nine medical conditions specified in §§ 67.13(d)(1)(i), (d)(2)(i), (e)(1), and (f)(1); 67.15(d)(1)(i), (d)(2)(i), (e)(1), and (f)(1); and 67.17(d)(1)(i), (d)(2)(i), (e)(1), and (f)(1). Since final denial under section 602 of the Federal Aviation Act of 1958 is required before an appeal can be taken to the National Transportation Safety Board, this change will speed and simplify the review process for additional applicants.

Under this amendment a final denial of a medical certificate may now be issued by one of these officials in all cases except those involving an unspecified mental or neurologic condition or general medical condition that is disqualifying because of a finding by the Federal Air Surgeon that the condition makes the applicant unable to perform airman duties safely or may reasonably be expected, within 2 years, to make him unable to perform those duties safely. (These conditions are specified in §§ 67.13(d)(1)(ii), (d)(2)(ii), and (f)(2); 67.15(d)(1)(ii), (d)(2)(ii), and (f)(2); and 67.17(d)(1)(ii), (d)(2)(ii), and (f)(2).) The cases frequently involve unique situations for which uniform guidance cannot be prepared and which require the application of special medical expertise and careful individualized review. For this reason, any final denial should be by the Federal Air Surgeon, personally, on behalf of the Administrator.

It should be noted that, notwithstanding this delegation, an applicant may still seek reconsideration by the Federal Air Surgeon of any denial by one of these officials. As appropriate during this reconsideration, the Federal Air Surgeon will continue the practice of consulting with a group of medical specialists from outside the FAA.

No Change in Policy

While this amendment changes the procedure by which certificates are issued to certain individuals who have been disqualified under §§ 67.13, 67.15, and 67.17, it does not reflect a change in the policies of the FAA with respect to determining whether those individuals are medically acceptable for exercise of airman privileges. The certificate process will continue to utilize, where appropriate, objective consultant medical specialists whose opinions will ensure specialized expertise in the review of medical certificate cases. Using every appropriate evaluative technique, the Federal Air Surgeon, acting on behalf of the Administrator, will continue to issue medical certificates to applicants who are able to perform airman duties without endangering safety in air commerce, after considering all available information on the applicant, the natural history of the disqualifying medical condition, and the need for any limitations.

Acceptance of Medical Risk by Certain Pilots

In deciding whether to issue a certificate under § 67.19, the Federal Air Surgeon must balance the needs and desires of the applicant against the risks to society. The FAA recognizes that individuals should be allowed the maximum freedom of choice, consistent with safety in air commerce, in deciding the extent to which their exercise of airman privileges should be limited by their personal health.

On the one hand, safety in air commerce demands that an individual with a potentially incapacitating medical condition not be allowed to operate aircraft under circumstances in which there would be a significant risk of injury to other persons in the air or on the ground, or of substantial damage to the property of others. On the other hand, there are situations in which such an individual could operate an aircraft for recreation or transportation, even when it is incidental to an occupation, without significant risks to others, but accepting some risks to his or her own person.

The commercial or airline transport pilot, in virtually every circumstance, has the life or property of another individual in his or her care. For this reason, if there is a reasonable risk that such a

pilot may experience an incapacitating medical event, even though that risk may be relatively small, the Federal Air Surgeon must consider the degree of protection to which the public is entitled in commercial operations. When transportation by an air carrier is involved, the Federal Aviation Act requires the Administrator, on whose behalf the Federal Air Surgeon acts, ''to consider the duty resting upon air carriers to perform their services with the highest possible degree of safety in the public interest'' (49 U.S.C. 1421).

The private pilot, however, is not in the business of providing safety transportation of another's person and property. If the risk of incapacitation is sufficiently remote, so that persons in other aircraft and on the ground are not endangered, it is necessary to impose those limitations on the pilot that would be designed to provide the extra level of protection to which the public is entitled in the case of a commercial or airline transport pilot. Thus, when reasonable safeguards of other individuals are provided, the private pilot should be allowed to return to flying after recovery from, or control of, potentially incapacitating disease has been clearly established. This amendment revises § 67.19 to state this policy governing special issuance of third-class medical certificates.

Changes to § 67.19

Notice 80–24 proposed to add a new § 67.18 to specifically state that exemptions from §§ 67.13, 67.15, and 67.17 are issued in accordance with part 11 (14 CFR part 11), and that petitions for exemption from that part are granted or denied by the Federal Air Surgeon. Since all relief to qualifying individuals is now expected to be provided through § 67.19, proposed § 67.18 is not being adopted.

Paragraph (b) of proposed § 67.18 would have specified the limitations and conditions that the Federal Air Surgeon may place on a certificate. This paragraph is being adopted as part of § 67.19. It provides that the Federal Air Surgeon may limit the duration of the certificate, condition the continued effect of the certificate on the results of subsequent medical tests, examinations, or evaluations, and impose any operational limitation on the certificate needed for safety. Historically, conditions and limitations such as these have been placed both on medical certificates issued under § 67.19 and on those issued under an exemption.

Functional Limitations

Revised § 67.19(b) provides that the Federal Air Surgeon may condition the continued effect of the certificate on compliance with a statement of functional limitations issued in coordination with the Director of Flight Operations or the Director's designee. Proposed § 67.18 would have required a separate finding of equivalent level of safety by the Director. Also, contrary to the proposal, these functional limitations will only be issued in connection with second- and third-class certificates.

While functional limitations such as ''not valid for pilot in command'' have been issued for all classes of medical certificates in the past, this rule limits their use to second- and third-class certificates only. First-class certificates will not be issued with limitations that would prevent the holder from exercising the only airman privilege for which such a certificate is required by the regulations, namely, acting as pilot in command in operations conducted under part 121 and certain operations under part 135. If the applicant's condition is such that he or she should not be allowed to act as pilot in command in those operations, a second-class certificate may be issued to medically qualified applicants to allow them to perform other crewmember duties.

Those airmen now holding first-class certificates with functional limitations may continue to be so certificated if there is no adverse change in the medical condition concerned and if they otherwise meet the standards. This will avoid any inequity that might result if this amendment were to be applied retroactively.

The FAA received a number of comments concerning functional limitations. The history of the FAA's use of these limitations will be further discussed in response to those comments.

Factors Considered

Proposed § 67.18 would have specified the factors that are considered in connection with a petition for exemption, if the applicant has one of the medical conditions (other than diabetes) excluded from § 67.19. These factors are not listed in § 67.19 to provide flexibility for medical advancements and to avoid the interpretation that they are all-inclusive or that, individually or collectively, they represent mandatory criteria. However, in determining eligibility for medical certification under § 67.19, those general factors will be considered.

In every case the FAA considers the natural history and severity of the problem, the period of satisfactory recovery since manifestation of the problem, and any treatment, as well as any continuing requirements for treatment, and its nature.

Personality Disorder, Psychosis, or Drug Dependence

In the case of an applicant who has had a personality disorder, psychosis, or drug dependence, the factors considered include: (1) Any current or recent psychiatric symptoms, aberrant behavior, or psychiatric or other medical findings; (2) the need for, or the use or abuse of, any clinical agents, for either therapeutic or recreational purposes; (3) any personality traits or other recognized factors involving the risk of future recurrence of the problem or the risk of other adverse events; and (4) the current psychiatric and psychological functional status and stability of the applicant, as determined by appropriate evaluative techniques.

Alcoholism

Where the applicant has an established medical history or clinical diagnosis of alcoholism and is not qualified under the standard revised by this amendment, the factors considered under § 67.19 would include: (1) The period of the applicant's abstention from alcohol; (2) the severity of the problem and how long it has existed; (3) the number of times treatment was sought and relapse occurred; (4) the quality of the final treatment effort; (5) the presence of residual medical complications, especially neurologic manifestations; (6) progress in marital, social, vocational, and educational areas, as appropriate, since rehabilitation began; (7) commitment to rehabilitation by virtue of continuing contacts with social or professional agencies, or both, and their opinions and recommendations; (8) any underlying personality difficulties that would either be disqualifying independently or adversely affect sustained abstinence; and (9) the findings of a recent psychiatric and psychologic evaluation.

Where there is a history or diagnosis of alcoholism, one factor proposed in Notice 80–24 will not be considered. The FAA agrees with the Air Line Pilots Association (ALPA) that the age of the onset of alcoholism and the individual's stability and adjustment before the onset can only be estimated, and are of questionable usefulness as evaluation factors. ALPA is an organization with considerable experience in the diagnosis, treatment, and rehabilitation of pilots with alcoholism.

Epilepsy or Disturbance of Consciousness

For an applicant with a history or diagnosis of epilepsy or disturbance of consciousness, the factors would include: (1) Any current or recent neurological symptoms or neurological or other medical findings; (2) the availability of an explanation for the cause of the problem that is acceptable in terms of risk for future recurrence; (3) any recognized factors involving the risk of future adverse neurological events or of other adverse events; and (4) the anatomic integrity and functional status of the nervous system as determined by appropriate evaluative techniques.

Cardiovascular Problems

In the case of an applicant who has a medical history or current diagnosis of a disqualifying cardiovascular problem, the factors would include: (1) Any current or recent cardiovascular symptom, or cardiovascular or other medical finding; (2) the functional capacity of the heart as measured by appropriate techniques; (3) the presence or absence of myocardial ischemia or of the anatomic propensity for it; (4) the presence of, or likelihood of, changes in heart rhythm that could affect the individual's level of consciousness or ability to perform in the aviation environment; and (5) any recognized factor involving the risk of future adverse cardiovascular events.

Diabetes

The Federal Air Surgeon will continue to deny certification to individuals who have an established medical history or clinical diagnosis of diabetes that is controlled by the use of insulin or another hypoglycemic drug. The FAA has not found circumstances under which such an individual may be certificated without significant risk of impairment of his or her faculties from an undetected drop in the level of blood sugar. If future medical advances should make certification possible, factors will be developed.

Clarification of Cardiovascular Standard

Notice 80–24 also proposed to amend §§ 67.13(e)(1), 67.15(e)(1), and 67.17(e)(1) which specifically disqualify applicants with a medical history or clinical diagnosis of a ''myocardial infarction'' (paragraph (e)(1)(i)) or ''angina pectoris or other evidence of coronary heart disease that the Federal Air Surgeon finds may reasonably be expected to lead to myocardial infarction'' (paragraph (e)(1)(ii). It proposed to revise (e)(1)(ii) to make it clear that angina pectoris is disqualifying in and of itself since a history

or diagnosis of angina pectoris normally indicates heart disease with significant risk of incapacity. It further proposed to add a paragraph (e)(1)(iii) to reflect the Federal Air Surgeon's consistent and well-established policy of denying applications for medical certificates under §§ 67.13, 67.15, to 67.17 by applicants with a known history of ''coronary heart disease, treated or untreated,'' whether or not the medical events specified in paragraph (i) or (ii) have occurred.

Although Notice 80–24 used the words ''coronary heart disease'' in proposed paragraph (e)(1)(iii), the comments received indicated public concern that the minimal and insignificant degrees of coronary atherosclerosis found in many young persons could be considered disqualifying. There also was concern that the rule could be used to require more invasive testing of applicants who had no history, signs, symptoms, or findings of disease. The agency agrees that change from the proposed wording for clarification is appropriate to relieve these concerns.

Accordingly, the proposed working of paragraph (e)(1)(iii) of these provisions is revised to read: ''Coronary heart disease that has required treatment or, if untreated, that has been symptomatic or clinically significant.'' This revision better expresses the intent of the proposal, i.e., to clarify the standard to reflect the policy of the FAA that individuals with a history of coronary heart disease not be medically certificated for the exercise of airman privileges under §§ 67.13, 67.15, or 67.17. These individuals may be certificated through the discretionary special issuance procedures of § 67.19 after a separate determination that their disease no longer represents a risk to aviation safety.

In the past, FAA practice has been to deny any application for medical certification by an applicant who has a history or finding of coronary heart disease, including those who have undergone coronary artery bypass surgery and grant medical certification, where possible, via the formal exemption process. This disqualification has been consistent with the medical standards of part 67. Subsequent medical certification, where possible, has been based upon acceptable evidence that the individual has adequately recovered and that his or her anatomic and physiologic cardiac status would not represent a significant risk to aviation safety in the subsequent exercise of airman privileges. Airmen were issued medical certificates through a grant of exemption that specified the airman privileges permitted and which required periodic medical reevaluation to detect the relapse or progression of disease known to occur ultimately in a large percentage of cases. This procedure protected the public while providing a means for relief for those individuals whose heart disease had stabilized sufficiently so as to pose an acceptable risk.

A number of commenters express the belief that the cardiovascular standards for certification under §§ 67.13(e)(1), 67.15(e)(1), and 67.17(e)(1) should be relaxed. Commenters also suggest that these standards be revised to set forth more detailed, objective criteria and tests by which medical certification can be determined. (In fact, the latter comment has been made the subject of a separate petition for rulemaking by a group of concerned pilots). Many commenters contend that the standards, and for that matter all of part 67, fail to take into account the advances in corrective surgery and treatment that have occurred since the part was issued.

Need for Review of Part 67

These comments, as they apply to the proposal, are discussed later in this preamble. The broader, substantive issues which they raise, however, cannot be resolved within the context of this rulemaking action. These issues warrant full consideration in a detailed and comprehensive review of the medical standards contained in part 67, and the FAA plans to undertake such a review in response to these comments.

Some commenters are asking, for example, that objective standards for recertification after corrective heart surgery by placed in §§ 67.13, 67.15, and 67.17. While the risks of incapacitation associated with coronary heart disease are well known (including crippling chest pain, arrythmia, infarction, and sudden death), predictions of the likelihood of such incapacitating events in particular cases have proven as difficult as predicting the course of the disease itself. Accordingly, in the past, it has been even more difficult to make generalizations about such risks in a manner that would enable the setting of objective standards to be applied to all applicants with known coronary artery disease.

Through the exemption process, the agency has recertificated many such applicants after extensive evaluations of their particular circumstances, including the need for particularized limitations, restrictions, or requirements for followup tests at intervals shorter than the normal duration of the certificate involved. Each of these evaluations has required examination of numerous factors relevant to risks, their interrelationship, and their variable significance as applied to each individual's known circumstances of health. Where a reasoned, albeit subjective, medical judgment can be made that there are no significant safety risks attributable to a particular pilot's condition, within any operational or other limitations prescribed, the pilot has been recertificated.

The question thus posed by many of the commenters is: Is it not feasible to articulate the considerations that support the issuance of these exemptions as objective, generally applicable regulatory standards and, in the process, relax the current standards appropriately? As will be discussed later, the answer is not readily available, as some commenters imply, from a review of medical literature, such as the report of the Eighth Bethesda Conference of the American College of Cardiology (1975).

Whether recommendations of either the Eighth Bethesda Conference or those who commented on Notice 80–24 can feasibly serve as generally-applicable regulatory certification standards is an issue requiring a major effort to obtain the views of the medical profession and of all interested parties. That effort will be undertaken as part of the review of all the medical standards in part 67.

Need for Interim Clarification

Pending completion of review of the certification standards reflected in current part 67, the need for immediate clarification of the cardiovascular standard remains. The NTSB's recent interpretations of the present standards in §§ 67.13(e)(1), 67.15(e)(1), and 67.17(e)(1) are in sharp conflict with the certification policies and regulatory history underlying these standards. In several medical certification decisions the NTSB found airmen qualified for unrestricted medical certificates despite a history of significant coronary heart disease. Recently the NTSB determined, upon appeal by several airmen, that a history of coronary heart disease treated by bypass surgery was not disqualifying under part 67. In these cases, the Board has equated the functional improvement afforded by such surgery to the elimination of significant risks of incapacitation associated with coronary artery disease. Under these determinations, the NTSB ordered the issuance of medical certificates of all three classes to these airmen. The certificates issued, therefore, contain neither limitations nor requirements for periodic medical re-evaluation. Further, the NTSB decisions limit the FAA's ability to obtain subsequent medically appropriate evaluations for determining continuing eligibility for certification is some cases. In others, the NTSB disregarded medical information the FAA considered adverse.

Under the Federal Aviation Act of 1958, section 602(b), it is the responsibility of the FAA to determine whether an applicant for an airman certificate is physically able to perform the duties pertaining to that certificate. Medical certification of airmen and the regulations pertaining to it are part of the FAA's fulfillment of that mandate. Section 602(b) also provides that an applicant who is denied certification by the FAA may petition the NTSB for review of the FAA's action, and the NTSB shall determine whether the airman meets the rules, regulations, or standards that the FAA has established. In several recent cases. the NTSB has interpreted the medical standards of §§ 67.13(e)(1), 67.15(e)(1), and 67.17(e)(1) in a manner inconsistent with the intent and practice of the FAA.

To meet the FAA's statutory responsibility to ensure safety in air commerce, interim clarification of the cardiovascular standard is necessary, pending substantive review of part 67. The rule as adopted makes it clear, pending further rulemaking, that an airman with a demonstrated history of coronary heart disease resulting in treatment or which has been otherwise clinically significant does not meet the requirements for certification under §§ 67.13, 67.15, or 67.17. These persons will continue to have the opportunity for discretionary certification under the special issuance procedure, which replaces the more cumbersome exemption process. A specific goal of the part 67 review to be undertaken will be to determine the extent to which these persons' medical qualifications can be evaluated under objective standards to be specified in the regulations themselves.

Revision of Alcoholism Standard

After the publication of Notice 80–24, the United States Court of Appeals for the Ninth Circuit held that §§ 67.13(d)(1)(i)(*c*), 67.15(d)(1)(i)(*c*), and 67.17(d)(1)(i)(*c*), disqualifying an applicant for airman medical certification because of an established medical history or clinical diagnosis of alcoholism, were invalid (*Jensen* v. *FAA*, 641 F.2d 797 (9th Cir. 1981)). This decision is based upon the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, 42 U.S.C. § 4651(c)(1) (Hughes Act):

> No person may be denied or deprived of Federal, civilian or other employment or a Federal professional or other license or right solely on the grounds of prior alcohol abuse or prior alcoholism.

The Court agreed, however, that the FAA may still consider alcoholism in its certification process and ''may enact regulations prohibiting certification of current alcoholics if that term is adequately defined.'' It further suggested that determinations of abstinence for appreciable periods of time and inquiry into the public health consequences of prior alcoholism were appropriate and complied with the Hughes Act.

The FAA has, in the past, complied with the policy of the Hughes Act by recertifying recovered alcoholics through the exemption process under which the subjective elements of rehabilitation were evalu-

ated on an individual basis and the regulations' prohibition waived in appropriate cases. In view of the Court's decision, however, the FAA is amending §§ 67.13(d)(1)*(c),* 67.15(d)(1)*(c),* and 67.17(d)(1)*(c)* to provide that an established medical history or clinical diagnosis of alcoholism is disqualifying for airman medical certification unless there is documented clinical evidence of recovery, satisfactory to the Federal Air Surgeon. The rule specifically states that this evidence must include sustained total abstinence from alcohol for not less than the preceding 2 years. Other factors considered include the problem's severity, frequency, and treatment; residual medical complications; progress in, and commitment to, rehabilitation; personality difficulties; and recent psychiatric and psychologic findings.

Individuals who do not meet the revised standard may be reconsidered for special issuance of a medical certificate under the provisions of § 67.19. As amended, this rule will allow the continuation of the successful programs that have enhanced aviation safety by encouraging self-identification, treatment, and rehabilitation, and the return to flying activities of many pilots.

Analysis of Comments

The FAA received approximately 300 public comments in response to Notice 80–24. Most of the comments address themselves to the revision of the cardiovascular standards and the perception that the proposed amendments alter the rights of airmen to appeal adverse certification decisions. Only 14 comments specifically address the proposed exemption procedures. Many comments refer to issues not pertinent to the proposed rule.

On February 3 and 4, 1981, the FAA held a public hearing to exchange views on the proposed amendment. Representatives of the aviation industry and interested individuals attended that meeting. Two hundred pages of testimony were taken.

Nature of Disqualification

One hundred twenty-two commenters object to making certain medical conditions, such as myocardial infarction, disqualifying under §§ 67.13, 67.15, and 67.17. The objection stems from the commenters' belief that part 67, which is more than 20 years old, fails to take into account the advances in corrective surgery and treatment that have occurred since the rule was issued. Many commenters characterize the regulations as making these conditions ''automatically disqualifying for life.'' Forty-two commenters recommend that cardiovascular problems not be ''absolutely'' disqualifying under §§ 67.13, 67.15, or 67.17, but only be considered as temporarily disqualifying until an individual has recovered sufficiently to be recertificated. Some commenters are concerned that coronary artery bypass surgery would be absolutely disqualifying under these provisions.

The FAA still considers the history or presence of significant heart disease, regardless of treatment, to preclude routine medical certification of the airmen affected. Further, any coronary heart disease that has required treatment is considered significant. While the ability to diagnose, evaluate, and intervene therapeutically has been enhanced by modern medical advancements, certification should be granted only after extensive individual evaluation and review by specialist, and discretionary requirements for periodic reevaluation and any appropriate operational or functional limitations remain necessary.

It is not accurate to characterize the disqualifying medical conditions in §§ 67.13, 67.15, and 67.17 as ''absolutely disqualifying'' or ''automatically disqualifying for life.'' Although individuals with a history or diagnosis of these conditions are ''disqualified'' under §§ 67.13, 67.15, or 67.17, the Federal Aviation Regulations still provide for individual consideration (formerly through the exemption process and now under § 67.19) using all appropriate and available evaluative techniques, including new developments, to determine what airman privileges, if any, can be safely exercised. That the specified conditions in §§ 67.13, 67.15, and 67.17 do not permanently prevent a person from exercising airman privileges is evident from past FAA decisions to certificate medically, after individual evaluation, thousands of airmen who did not meet these standards. As already noted, revised § 67.19 provides an administratively simpler mechanism for these actions, removing any requirement that airmen obtain exemptions.

Breadth of the Cardiovascular Standard

One major pilots' organization expresses concern that the proposed change in the wording of the cardiovascular standard seems to be a reversion to an unwarranted and unnecessarily harsh and broad standard. The commenter suggests that it be revised to read, ''No established medical history or clinical diagnosis of any of the following: (i) Myocardial infarction; (ii) angina pectoris; (iii) coronary heart disease, treated or untreated, if symptomatic and clinically significant.''

As already noted, the FAA recognizes that the term ''coronary heart disease'' is perceived by many commenters as including nonsignificant coronary atherosclerosis. Therefore, the interim standard, as adopted, has been expressed in language similar to that suggested by this commenter.

Exemptions for Alcoholism

The same pilots' organization strongly recommends that a history or diagnosis of alcoholism no longer should require a grant of exemption before certification is possible. In addition to the revision of the standard already discussed, § 67.19 now permits certification, when appropriate, through special issuance procedures without need for the formal exemption process, regardless of the medical condition involved.

Right of Appeal to the NTSB

One hundred fifteen commenters express concern that protection be given to the right to appeal any adverse certification decision by the Federal Air Surgeon, particularly after the denial of certification because of coronary heart disease.

Neither the proposed nor the final rule deprives any airman of his or her appeal rights. An airman still has the right to request review by the NTSB of any denial of certification by the FAA based on the standards in §§ 67.13, 67.15, and 67.17, and that review will determine whether the denial was proper under those provisions. The intent of the revision of the heart disease standard, pending review of all part 67 medical standards, is not to deprive any individual of these rights, but to preclude further misinterpretations of the cardiovascular standards by the NTSB that have already resulted in issuing unrestricted and unmonitored medical certificates of all classes to individuals with histories of significant heart disease.

The interim change in the wording of the rule reflects the knowledge that a history or diagnosis of angina pectoris normally indicates heart disease with significant risk of incapacitation whether or not it can be stated that a myocardial infarction will result. The change also reflects the knowledge that no treatment, including surgery, can be relied upon to cure coronary heart disease, to eliminate the significant rate of disease progression, or to eliminate the risks of incapacitation attributable to the disease. Since, in some cases involving coronary artery bypass surgery and angina pectoris, the NTSB has interpreted the medical standards of the Federal Aviation Regulations as permitting unlimited and unmonitored certification, sometimes without successful completion of the medical evaluations considered necessary by the FAA, this revision of the language of the standard is necessary to ensure that the FAA fulfills its responsibility to promulgate rules necessary to provide safety in air commerce. However, no change in FAA certification policy or practice regarding cardiovascular disease is embodied in this revision. This has been evidenced by the longstanding uniformity of FAA practice in this regard and the regulatory history dating back to the original 1958 Flight Safety Foundation Medical Advisory Panel recommendations. Further, those airmen who have adequately recovered and whose medical evaluations indicate the absence of significant risk may be certificated, with appropriate limitations or conditions, under the discretionary special issuance provisions of § 67.19.

List of Criteria or Tests

One hundred forty-four commenters request that the standards include a list of specific criteria or tests which applicants for certification must satisfy. Some commenters mention the report of the Eighth Bethesda Conference of the American College of Cardiology (1975) in this regard.

As already noted, the FAA intends to consider these suggestions in conjunction with an overall review of the medical certification standards in part 67. However, it is important to state here why these interim cardiovascular standards are being issued in a format that is clearly contrary to that desired by these commenters.

In the past part 67 has stated certain medical conditions that are disqualifying in general terms. There are some areas such as vision where it has been possible to state minimum requirements by listing specific parameters. However, in other areas it has been the opinion of the FAA that the nature of medical science and the complexity and variability of the medical factors, as they affect different individuals and thereby influence flight safety, have made it impractical or impossible to promulgate generally applicable medical standards in any other format.

The FAA recognizes the need to inform the public as fully as possible of the basis for certification decisions. Medical evaluation, however, has rested heavily upon professional judgment regarding the relative weight and significant accorded every element of information available about the applicant. The complexity and variability of the medical factors considered have made it impractical and unwise to attempt to make a definitive listing of tests or examinations, as well as result parameters, which would categorically qualify or disqualify applicants with any given medical history or diagnosis. Even if information developed in the review of part 67 indicates that such a listing is practical, care must be taken that it does not result in arbitrary denial of certification to some individuals while providing for certification of others whose histories or current conditions indicate an unacceptable risk to aviation safety. In such a standard

there would have to be room for consideration of individual physiological differences; variations in disease manifestations; mitigating, exacerbating, or interactive findings; and the availability of alternative evaluative technology.

It should be noted that this preamble does specify the categories of information currently considered important in determining medical status where there is history or diagnosis of those severe disorders which permit certification only through the special issuance procedure. However, individual cases may involve consideration of additional factors, or exclusion of listed factors that are not pertinent. Information needed with respect to any factor, if not contained in the applicant's records, will be requested at the time of application for a special issuance.

Consideration of the pertinent factors in each case, however, determines the scope of the medical investigation and the appropriate methodology. Aeromedical certification decisions will be based, when appropriate, upon review by medical specialists of all data thus obtained.

Eighth Bethesda Conference

The report of the Eighth Bethesda Conference of the American College of Cardiology, a collection of scientific papers, has been used extensively by the FAA in developing certification policy and in making individual certification decisions. In most respects its recommendations closely followed already existing FAA procedures. It addresses considerations pertinent to the diagnostic and prognostic evaluation of individuals having or suspected of having heart disease. The FAA will continue to use this document as it was intended, that is, as a technical and policy resource.

Epidemiological Factors

A physician, a medical college professor, notes that more than half of all deaths from heart disease are due to sudden arrhythmias; that is, irregularities in the heart beat, which may not be preceded by other symptoms of heart disease, such as angina pectoris or myocardial infarction. This commenter describes epidemiologic risks for sudden death in relation to factors such as age, smoking history, and various electrocardiographic findings. He suggests their use in certification decisions. The detailed evaluations required for special issuance of medical certificates under § 67.19 presently provide for careful consideration of all risk factors. Consideration of how these factors might lend themselves to the development of specific requirements regarding each identified risk factor will be welcomed in the course of the part 67 review.

Diabetes

An organization composed of a large number of aircraft owners and pilots comments that Notice 80–24, in part, is inconsistent with the Federal Aviation Act of 1958 (FA Act) and with part 11 of the Federal Aviation Regulations. It argues that because these provisions authorize and provide procedures for issuing exemptions in the case of any medical condition when it is in the public interest, the FAA may not prejudge any medical condition. This comment is based upon the FAA policy regarding diabetes requiring insulin or other hypoglycemic agent for control. Notice 80–24 indicates that the FAA has not found information demonstrating the circumstances under which an individual with drug-controlled diabetes could be certificated and, therefore, no factors were included.

The FA Act only allows issuing airman certificates to applicants who are physically able to carry out the airman duties they seek to perform. The fact that procedures are available for certification of all individuals, under part 11 or otherwise, does not preclude the Federal Aviation Administrator, acting through the Federal Air Surgeon, from fulfilling this statutory requirement when he determines that all individuals with a specific medical condition cannot safely exercise airman privileges. The authority to grant exemptions from the Federal Aviation Regulations is discretionary. A policy that denies exemptions to every person disqualified under a specific section neither violates the Federal Aviation Act of 1958 nor is inconsistent with part 11 of the regulations.

Drug-controlled diabetes in a pilot still represents an unacceptable risk to flight safety. If, in the future, information demonstrating that medical technology has advanced to the point that diabetes can be controlled without significant risk of incapacitation from hypoglycemia or other complications becomes available to the FAA, consideration for special issuance of a medical certificate under § 67.19 will be possible.

Accident Statistics

The same organization objects to the proposed changes in the cardiovascular standards in §§ 67.13(e)(1), 67.15(e)(1) and 67.17(e)(1) on the basis that they are not justified by accident experience. The FAA does not consider it necessary to justify every rule with accident statistics. Positive regulatory actions

designed to promote or maintain a high level of aviation safety are preferred and more appropriate than those offered in response to system failure. The low incidence of medically related accidents must be considered testimony to the effectiveness of the medical certification system, not as an argument that medical certification should be liberalized. The current changes are needed to eliminate ambiguity.

Court Decision

The organization also suggests that the proposed changes are not responsive to the Court's decision in *Delta Air Lines, Inc.* v. *United States, et al.* However, the FAA considers this revision to part 67 to be fully responsive to the Court's decision. This amended rule makes clear that discretionary airman medical certification is possible in many cases despite a history or diagnosis of serious disease, and it provides relief through procedures more efficient than formal exemptions, and, thus, meets the Court's objection that this relief has been provided without compliance with the Administrative Procedure Act. It specifically expresses the delegated authority of the Federal Air Surgeon, on behalf of the Administrator, to issue medical certificates contingent upon compliance with operational limitations or, after coordination with the Director of Flight Operations, functional limitations for second- and third-class certificates.

Functional Limitations

One major professional pilots' organization and an organization representing a large number of other professional flight crewmembers oppose the proposal to permit the Federal Air Surgeon to issue medical certificates contingent upon a statement of functional limitations issued only by the Director of Flight Operations. They have no objection, however, to use of these limitations. These commenters suggest that involving the Director as a decisionmaker in determinations that are solely medical is an unwarranted reversal of FAA's policy of permitting only those with specific technical knowledge and specific expertise to make regulatory decisions. The commenters believe this would be confusing. Both commenters suggest that the authority should rest solely with the Federal Air Surgeon.

The FAA agrees that while the Director of Flight Operations has the capability to test an applicant's current ability to pilot an aircraft, he does not have the expertise to predict the consequences of an airman's medical condition. The proposed procedure is changed, therefore, to provide for determining functional limitations, where appropriate, by the Federal Air Surgeon in coordination with the Director of Flight Operations. For the reasons already noted, these limitations an authorized only for second- and third-class airman medical certification.

Commenters for one airline and for an association of airlines oppose the use of functional limitations to designate the cockpit duties of pilots. The airline believes that any regulation incorporating such limitations would impair the ability of airlines to perform their services with the highest possible degree of safety in the public interest. Further, this commenter states that if a pilot is medically qualified to justify the issuance of a first-class medical certificate, then he or she should be permitted to exercise all of the privileges of the certificate; that is, pilot in command, first officer, or second officer. The Airline believes that if the airman is not medically qualified, then he or she should not be issued the certificate. The association objects to granting functionally limited certificates to airmen not qualified by airline standards in the belief that it undermines the airline prerogative to determine the placement and duties of its flight crewmembers.

In the past, the FAA has used functional limitations to specifically match the duties an airman is authorized to perform with his or her physical capabilities and overall medical condition. Where some very small but acceptable element of existing aviation risk was perceived through medical evaluation, an exemption was granted or a certificate specially issued with appropriate followup requirements and limitations of function or responsibility. These limitations and reevaluation requirements ensured a level of safety equivalent to that in cases of airmen certified under the standards. In the belief that the class of certificate issued was inconsequential in cases where specific individual evaluation and specific limitations in authorized duties were delineated, the FAA applied this policy to all classes of medical certificates. Experience over 20 years has not indicated any adverse effect on safety.

As already noticed, first-class airman medical certificates will no longer be issued to individuals considered unacceptable for unlimited performance of all airman duties associated with a first-class certificate. Under the provisions of § 67.19, the FAA, where appropriate, will issue second- or third-class airman medical certificates with any operational or functional limitations that the Federal Air Surgeon deems necessary in the public interest to provide a level of safety equivalent to that provided by § 67.15 or § 67.17, as appropriate. In cases of airmen who previously have been issued first-class medical certificates with functional limitations and who have maintained certification without adverse medical change or functional difficulty, the FAA will continue to issue first-class certificates to them if the applicants otherwise remain qualified.

Mental Conditions

One professional organization suggests that the grouping of personality disorders, psychosis, and drug dependence into a single category is an arbitrary and misleading association since ambiguity exists within diagnoses. The commenter further expresses concern that the proposed rule would minimize the diagnostic input from psychologists and social workers. A multidisciplinary format is suggested with the rule specifically requiring assessment of affected airmen by psychiatrists, psychologists, and social workers.

The evaluation factors listed are public guidelines regarding the information considered significant in evaluating individuals disqualified under specific medical standards. The groupings are for convenience only, reflect the wording of the actual standards, and indicate only that the same factors are applicable for each of the grouped conditions. The factors are not necessarily all-inclusive and all may not be appropriate in every case.

The FAA accepts and considers medical evaluations from all recognized professional workers, though it sometimes requires specific information available only from workers in particular disciplines. When appropriate, psychiatrists, psychologists, and social workers are included. A ''team'' approach to diagnosis and treatment frequently is noted. Because the information needed must be provided and fees paid by the airman, however, the FAA requests only what is necessary for certification decisions. A rule that requires multiple professional consultations in every case would be unnecessarily burdensome.

Treatment Effort

The same professional organization also suggests that evaluation of an individual with a history of alcoholism should include an assessment of ''the quality of the final treatment response'' rather than, as proposed, ''the quality of the final treatment effort.'' Determining the final response is, of course, the objective in consideration of all factors. By use of the word ''effort,'' the FAA includes consideration of the quality of participation of the applicant in his or her treatment as well as the quality of the treatment facilities utilized.

Classification as a Nonsignificant Regulation

Notice 80–24 stated that the FAA had determined that the regulation proposed was not considered to be significant under the Department of Transportation Regulatory Policies and Procedures (44 FR 11034; February 26, 1979). Twenty-seven commenters object to the ''nonsignificant'' classification placed on the proposed rule, citing the criteria for significance in the DOT Policies and Procedures in their comments. The commenters contend that the proposal should have received the review and concurrence of the Secretary of Transportation, as is required for significant regulatory actions.

Objections to the proposal's classification as nonsignificant were also raised at the public hearing held on February 3 and 4, 1981. The FAA advised the participants that its determination that the proposed action was not significant under the criteria of the DOT order would be reviewed in the light of all comments received in response to the notice and those presented at the public hearing. The FAA encouraged all interested individuals to provide to the rulemaking docket their comments regarding the specific impact of the proposal.

The FAA's initial determination that the proposal was not significant was reviewed by the Office of the Secretary of Transportation before it was issued, and the Department's Semiannual Regulations Agenda and Review List, issued by the Secretary (46 FR 20036; April 2, 1981), indicated agreement in this determination.

Because of controversy evidenced by these comments, the FAA has determined that this rulemaking should be considered significant under the criteria of the Department of Transportation Regulatory Policies and Procedures, and under those procedures, it has received review by the Office of the Secretary of Transportation. This amendment has also been reviewed by that office under current DOT procedures implementing Executive Order 12291, and in compliance with the Executive Order, has been reviewed by the Office of Management and Budget.

Public Interest

Granting airmen relief provided by this amendment is supported by the FAA's 20-year history with the medical exemption process. Through this experience, the FAA has determined that the public interest is best served when airmen who know, or have reason to believe, they are experiencing a medical problem are encouraged to submit themselves to medical treatment and rehabilitation as soon as possible. These airmen include commercial and air carrier pilots who depend on their medical certificate for their livelihood and on whom, in turn, the public depends for safe air travel. They also include general aviation pilots who share the airspace with those pilots and the traveling public.

Providing means by which these airmen may subsequently obtain a medical certificate discourages concealment of a disqualifying medical condition to avoid the permanent loss of employment or airman privileges. This incentive is necessary because, while there has been a marked improvement in the evaluation and treatment of many of these conditions, they cannot always be detected by a routine medical examination.

Encouraging airmen to seek medical treatment as early as possible benefits both the public and the airman. The public is protected from the risk that the airman may become incapacitated while operating an aircraft. The public also benefits because airmen who seek early treatment and voluntarily provide accurate medical information contribute to safety in air commerce. Voluntary disclosure to the FAA allows careful assessment of the condition and the opportunity for special periodic medical surveillance in the event that medical certification is considered appropriate. This contributes substantially to the fund of knowledge regarding these conditions and aviation medicine generally.

The airman's early recovery and return to flying is facilitated by disclosure, since early treatment substantially improves the prognosis for many conditions.

Economic and Social Benefits

Issuing certificates under § 67.19 provides economic and social benefits for the airman, the aviation community, and the general public. First- and second-class medical certificates allow applicants to participate in commercial aviation activities without compromising safety and reduce the likelihood that the petitioner will become economically dependent upon the public. Training costs to replace individuals who would otherwise be unable to act as airmen in commercial operations or for private hire are avoided and the pool of qualified aviation personnel is maintained. Third-class medical certificates allow applicants to pursue aviation activities without compromising safety and thereby contribute to the promotion of civil aviation generally.

Regulatory Evaluation

The FAA conducted a regulatory evaluation for this final rulemaking action. The FAA determined that this rule imposes no new requirements on airmen seeking first-, second-, or third-class medical certificates. However, the FAA has determined that this rule may conceivably impose minimal-to-negligible costs in the aggregate by impacting those individuals who have histories of significant heart disease, and through the NTSB appeals process, might have ultimately been issued unrestricted and unmonitored medical certificates. While the new regulation does not preclude an individual's right of appeal to the NTSB, it does clarify the intent with respect to cardiovascular standards and eliminates the possibility of further misinterpretation. Therefore, a few individuals who might otherwise be considered certifiable by the NTSB under that misinterpretation may be restricted from receiving medical certificates under the new regulations. Furthermore, this rule imposes no additional costs on the Federal Government.

Implementing this rule provides benefits in terms of cost savings in the aggregate to certain airmen who apply for medical certificates, especially those airmen who were disqualified under the conditions of previous regulations from receiving medical certificates because of certain medical conditions; to businesses which operate aircraft; and to the Federal Government. Specifically, this rule allows the initial qualification under §§ 67.13, 67.15, and 67.17 of individuals with a history of alcoholism that seek medical certificates where there is established clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including sustained total abstinence for not less than the 2 preceding years. Prior to this rule, a medical certificate for an individual with such a history could only be sought through the exemption process. Therefore, this rule eliminates individual processing costs and time lost due to the exemption process for airmen with this condition.

Additionally, this amendment provides means for discretionary special issuance of medical certificates to certain airmen who are otherwise disqualified because of a personality disorder that is severe enough to have manifested itself by repeated overt acts, psychosis, alcoholism, drug dependence, epilepsy, disturbance of consciousness without satisfactory medical explanation of the cause, myocardial infarction, angina pectoris or other evidence of coronary heart disease, or diabetes mellitus that requires insulin or other hypoglycemic drugs for control. Airmen with these medical conditions are expected to be granted relief, where appropriate, through a more immediate means of special issuance review action, thus eliminating the processing costs of seeking exemptions and reducing time lost in awaiting decisions. This rule also provides for further decentralization of FAA decision authority, thereby reducing the applicant's waiting time for a decision in such cases.

The total cost savings to airmen who apply for medical certificates in a given year will vary according to the number of airmen who would have been disqualified from receiving medical certificates under conditions of previous regulations and who are now provided relief through either initial qualification (in the case of alcoholism) or immediate review for special issuance of medical certificates; and the

value of time foregone, both personal and business-related, for applicants that sought medical certificates through the exemption process and special issuance process and are now provided a more timely review process. According to the FAA's *1980 Aeromedical Certification Statistical Handbook* for the period of 1961–1980, there were approximately 8,000 petitions for exemption filed that would now qualify for special issuance review. Cost savings, in terms of reduced training costs and reduced aircraft downtime, are also expected for businesses which operate aircraft.

Important cost savings will accrue to the Federal Government. This rule reduces the administrative case review time of documents, decentralizes the decision authority in special issuance cases, and increases FAA system responsiveness.

Accordingly, the benefits of this regulation outweigh any costs that may be incurred. However, the magnitude of the benefits and costs, and the number of small entities affected, do not involve a significant economic impact on a substantial number of small entities.

Adoption of the Amendments

Accordingly, part 67 of the Federal Aviation Regulations (14 CFR part 67) is amended, effective May 17, 1982.

Secs. 313(a), 601, and 602 of the Federal Aviation Act of 1958, as amended (49 U.S.C. 1354(a), 1421, and 1422); sec. 6(c) of the Department of Transportation Act (49 U.S.C. 1655(c)).

NOTE: Since this final rule amends part 67 to incorporate relief to airmen currently provided by the exemption process and does not impose any new cost or other economic burden on airmen, the FAA has determined that this is not a major regulation under Executive Order 12291. For these reasons and for the other reasons stated above, it is certified that, under the criteria of the Regulatory Flexibility Act, this final rule will not have a significant economic impact on a substantial number of small entities. However, because of the controversy over some aspects of the proposal, the FAA has determined that this regulation should be considered significant under the Department of Transportation Regulatory Policies and Procedures (44 FR 11034; February 26, 1979). A copy of the final regulatory evaluation prepared for this action is contained in the regulatory docket. A copy of it may be obtained by contacting the person identified under the caption ''FOR FURTHER INFORMATION CONTACT.''

Amendment 67–12

Fees for Certification of Foreign Airmen and Air Agencies

Adopted: July 21, 1982 **Effective: October 18, 1982**

(Published in 47 FR 35690, August 16, 1982)

SUMMARY: These amendments establish (1) a schedule of fees for issuing certain airman and repair station certificates to certain foreign nationals outside the United States; (2) a method for collecting those fees; and (3) a need requirement for original certification of those airmen (a need requirement has already been established for issuing certificates to foreign repair stations). These amendments are designed primarily to recover costs the FAA incurs in certificating foreign airmen and repair stations overseas. The amendment requires that certificates be issued overseas to foreign nationals only when needed to operate or assure the continued airworthiness of U.S.-registered civil aircraft. Finally, this amendment is in keeping with the intent of Congress.

FOR FURTHER INFORMATION CONTACT: Kathleen W. Gorman, Chief, International Analysis & Coordination Division (AIA–300), Federal Aviation Administration, 800 Independence Avenue, SW., Washington, DC 20591; telephone (202) 426–3230; or Leo Weston, Chief, General Aviation and Commercial Branch (AWS–340), Aircraft Maintenance Division, Federal Aviation Administration, 800 Independence Avenue, SW., Washington, DC 20591; telephone (202) 426–3546; or Arthur C. Jones, Chief, Certification Branch (AFO–840), General Aviation and Commercial Division, Federal Aviation Administration, 800 Independence Avenue, SW., Washington, DC 20591; telephone (202) 426–8196

SUPPLEMENTARY INFORMATION:

Background

On July 17, 1981, the FAA issued Notice of Proposed Rulemaking No. 81–12 (46 FR 40529; August 10, 1982) proposing: 1) to establish fees for issuance of certain airman and repair station certificates to foreign nationals residing outside the United States; 2) a method of collecting those fees; 3) a need requirement for those airmen; and 4) a 2-year limitation on the validity of certificates issued to foreign nationals. All interested persons have been given an opportunity to participate in the making of the proposed regulations, and due consideration has been given to all matters presented.

Statutory

Title VI of the Federal Aviation Act of 1958, as amended (the Act), gives the Administrator authority to issue certificates for airmen, instructors, schools, and repair stations. Section 602(b) states that the Administrator may, at his discretion, prohibit or restrict the issuance of airmen certificates to aliens.

In addition, the Administrator is charged with establishing a fair and equitable system for recovering full costs expended for any service, such as issuing the certificates discussed in Notice 81–12, which provides a special benefit to an individual beyond those which accrue to the general public. Title V of the Independent Offices Appropriation Act of 1952 (31 U.S.C. 483a) states:

> It is the sense of the Congress that any work, service, publication, report, document, benefit, privilege, authority, use, franchise, license, permit, certificate, registration, or similar thing of value or utility performed, furnished, provided, granted, prepared or issued by any Federal Agency . . . to or for any person (including groups, associations, organizations, partnerships, corporations, or businesses), except those engaged in the transaction of official business of the Government, shall be self-sustaining to the full extent possible. . . .

To give full effect to this sense of Congress, § 483a further provides:

> The head of each Federal agency is authorized by regulation (which, in the case of agencies in the executive branch, shall be as uniform as practicable and subject to such policies as the President may prescribe) to prescribe therefor such fee, charge, or price, if any, as he shall determine, in case none exists, or redetermine, in case of any existing one, to be fair and equitable taking into consideration direct and indirect cost to the Government, value to the recipient, public policy or interest served, and other pertinent facts. . .

The statute provides that the amounts collected shall be paid into the Treasury as miscellaneous receipts.

OMB Guidance

To aid in establishing fee schedules, the Office of Management and Budget (OMB) has prescribed in Circular No. A–25, ''User Charges,'' the general guidelines to be used in developing an equitable and reasonable uniform system of charges of certain Government services and property.

The circular provides that ''Where a service (or privilege) provides special benefits to an identifiable recipient above and beyond those which accrue to the public at large, a charge should be imposed to recover the full cost to the Federal Government of rendering that service.'' Circular No. A–25 specifies:

A special benefit will be considered to accrue and a charge should be imposed when a Government-rendered service:

> (a) Enables the beneficiary to obtain more immediate or substantial gains or values (which may or may not be measurable in monetary terms) than those which accrue to the general public (e.g., receiving a patent, crop insurance, or license to carry on a specific business); or
>
> (b) Provides business stability or assures public confidence in the business activity of the beneficiary (i.e., certificates of necessity and convenience [sic: convenience and necessity] for airline routes, or safety inspections of craft); or
>
> (c) Is performed at the request of the recipient and is above and beyond the services regularly received by other members of the same industry or group, or of the general public (e.g., receiving passport, visa, airman's certificate, or an inspection after regular duty hours).

Previous Notices

Consistent with the guidelines in Circular No. A–25, in recent years the FAA issued several notices of proposed rulemaking to establish a schedule of fees for various FAA activities (Notices 67–17, 67–

18, and 78–6). The schedules were predicated, however, on the FAA's systemwide total cost of performing specific certification activities, and no attempt was made to distinguish the far greater costs incurred performing certification services overseas from costs incurred performing similar services in the United States. The proposed fee schedules were never implemented. Beginning in 1973, the Congress annually prohibited implementing fee schedules through language in the appropriations legislation for the Department of Transportation. In 1979, this prohibition was deleted from the appropriations legislation but included in Section 45 of the Airline Deregulation Act of 1978:

> Notwithstanding any other provision of law, neither the Secretary of Transportation nor the Administrator of the Federal Aviation Administration shall collect any fee, charge, or price for any approval, test, authorization, certificate, permit, registration, conveyance, or rating relating to any aspect of aviation (1) which is in excess of the fee, charge, or price for such approval, test, authorization, certificate, permit, registration, conveyance, or rating which was in effect on January 1, 1973, or (2) which did not exist on January 1, 1973, until all such fees, charges, and prices are reviewed and approved by Congress.

Before 1970, a liberal policy prevailed within the FAA regarding acceptance of applications for airman and air agency certificates by foreign nationals residing outside the United States. During the 1970's, however, the continuous expansion in worldwide demand for FAA certification services, along with the adverse movement of currency exchange rates against the U.S. dollar, placed an undue burden on FAA budgetary and manpower resources.

Simultaneously, the appropriateness of this policy was called into question. The technical sophistication of many foreign civil aviation certification authorities has been strengthened by general economic growth and civil aviation technical assistance provided by the International Civil Aviation Organization (ICAO), the United States, and other nations. Overly free exportation of U.S. certificates could deter the development of competent, indigenous certification programs. The FAA wishes to avoid that result and to encourage foreign governments in developing aeronautical codes and administrative capabilities which would permit them to conduct their own certification functions.

For these reasons the Administrator began a practice of restricting recertification of foreign nationals, primarily through the requirement that the applicant show that such certification is required to operate or assure the continued airworthiness of U.S.-registered civil aircraft (need requirement). This need requirement was incorporated in regulations governing certification of foreign repair stations (14 CFR § 145.71). To further ensure consistent implementation of this practice, these amendments incorporate the need requirement in the Federal Aviation Regulations (14 CFR parts 61, 63, 65 and 67) governing initial airman certification.

In 1980 Congress passed the International Air Transportation Competition Act of 1979, giving the Administrator authority to establish fee schedules for airman and repair station certificates issued outside the United States. Section 28 of that Act amends § 45 of the Airline Deregulation Act of 1978 to read as follows:

> Nothing in this section shall prohibit the Secretary of Transportation or the Administrator from collecting a fee, charge, or price for any test, authorization, certificate, permit, or rating, administered or issued outside the United States, relating to any airman or repair station.

Although § 28 provides discretionary authority to collect fees from any applicant residing outside the United States, this regulatory amendment establishes fees to be collected only from foreign nationals residing outside the United States.

Discussion of Amendments

In keeping with the authority granted under § 28 of the International Air Transportation Competition Act of 1979, these amendments establish a schedule of fair and equitable fees for airman and repair station certification activities performed for foreign nationals outside the United States. For purposes of these amendments, persons having resident alien status are treated the same as U.S. citizens and will not be charged for FAA certification should it occur outside the United States.

Fixed fees for airman certificates and hourly rates for assessing fees for repair station certificates are included in the regulations as a new appendix to part 187 entitled ''Fee Schedule for Certification Services Performed Outside the United States on Behalf of Foreign Nationals Other Than Resident Aliens.'' (Fixed fees could not be derived for repair station certificates because the time involved varies widely.) All fees are derived from total certification costs and include direct and indirect labor costs, overhead costs, interest recovery, depreciation, and space rent costs, where appropriate. The fees therefore implement OMB Circular No. A–25 and will recover all airman and repair station certification costs incurred by the FAA in issuing original certificates to foreign nationals.

No fees will be charged for renewing airman certificates. A fee will continue to be charged for replacing stolen or lost certificates. In addition, fees will be assessed for reissuing repair station certificates since reissuing these certificates requires considerable expenditure of FAA technical resources. However, because the technical resources expended in reissuing Inspection Authorization Certificates under § 65.91 have, upon further review, been determined to be minimal, the proposed fee for renewing these certificates is not adopted. In addition, a requirement has been added that checks tendered for fee payment must be drawn on a U.S. bank. This requirement has been added because Treasury depositaries have established minimum check amounts acceptable for deposit. Without this requirement a substantial number of checks submitted for fees would be uncollectible.

These amendments also formally establish a need requirement for issuing certificates to foreign applicants outside the United States; that is, the certificates must be needed for the operation or continued airworthiness of U.S.-registered aircraft. Foreign nationals who are resident aliens will not have to meet this requirement.

The FAA does not currently issue to foreign nationals overseas: (1) Any certificates for Pilot Schools (part 141), Ground Instructors (part 143), Aviation Maintenance Technical Schools (part 147), or Parachute Lofts (part 149), and (2) certificates issued under subparts of part 65 for Aircraft Dispatchers (subpart C), Repairmen (subpart E), or Parachute Riggers (subpart F). Consequently, those parts and subparts have not been amended to include the need requirement and other requirements included in these amendments. Subpart B of part 65 similarly has not been amended although it is understood the current practice of issuing under this subpart a limited number of air traffic control tower operator certificates overseas to foreign nationals to operate civilian/military joint-use facilities in Europe will be continued under an appropriate agreement with the Department of Defense.

Notice 81–12 proposed a 2-year validity period for each certificate issued to a foreign national who is not a resident alien. In this regard, the FAA has determined that additional information concerning this issue is needed. Therefore the proposal concerning the 2-year validity period is not adopted at this time. The FAA may, however, initiate rulemaking in this area in the future. It should be noted that withdrawing this proposal does not alter the current renewal requirements for repair station, flight instructor, inspection authorization, certain flight engineer, and student pilot certificates.

Fee Collection

For airman certificates, the FAA will collect the fees at the time of application for a certificate of rating, after first ascertaining the applicant's eligibility. The Flight Standards Office (FSO) or designated examiner will determine whether the applicant meets the need requirement and other preliminary eligibility requirements, such as age and currency. If these requirements are met, the FSO will issue a receipt as evidence of payment and forward the applicable fee to the regional accounting office serving the area. Fees must be in the form of a check, money order, or draft payable in U.S. currency to the Federal Aviation Administration and drawn on a U.S. bank. No application will be acted upon until evidence of the payment has been presented. There will be no refund of any fee payment for any examination which the applicant fails to pass. However, if an applicant notifies the FAA at least one week before a scheduled examination that he wishes it cancelled, the FAA will refund the fee payment after deducting a minimal service charge to cover the cost of processing the application.

In the case of repair station certificates, applicants will submit as prepayment the costs required for 25 hours of technical activity and 7.5 hours of clerical activity for original certification or approval of a change of location or housing of facilities, or 10 hours of technical activity and 3 hours of clerical activity for an amendment or renewal of the certificate due to an added rating or change in ownership, at the hourly rates specified in the appendix to part 187. This repayment will be processed in the same fashion as fees collected for airman certificates. If the time required in actual certification is less than 25 and 7.5 hours or 10 and 3 hours, the FAA will submit to the applicant a refund to cover the difference between prepayment and actual costs. Conversely, if the time required is greater, the applicant will be required to submit the additional funds. As in the case of airman certificates, applicants for repair station certificates must pay these fees, regardless of whether a certificate is awarded.

In Notice 81–12, the agency proposed to amend § 65.15a. That section had previously been revoked by another regulatory action and, therefore, the proposed amendment was inappropriate. Therefore, the proposal to amend § 65.15a is withdrawn.

Analysis of Comments

The FAA received 39 comments in response to Notice 81–12, 29 of which originated from the same pilot school in Belgium. Most of these comments, particularly those originating from the Belgian pilot school, argue that the proposed 2-year renewal requirement would inhibit the safe expansion of

aviation in many parts of the world by denying FAA airman certificates to many foreign nationals overseas who may not be able to demonstrate periodically that they are operating or assuring the continued airworthiness of U.S.-registered aircraft. These commenters further argue that, as a result, aviation safety would suffer, the world market for aviation products and services would decrease, and most important, the current orientation of many pilots toward U.S. products and services would be substantially reduced.

Regarding this latter effect, the commenters argue the proposed 2-year renewal requirement would decrease U.S. general aviation exports by reducing the number of pilots trained on U.S. equipment. As one commenter states, ''Foreign pilots trained on U.S.-aircraft will develop U.S.-brand loyalty, which would reflect when purchasing aircraft in their native countries'' (sic). Those foreign nationals holding FAA flight instructor certificates apparently feel that the inability of some foreign nationals to meet the continuing need requirement would cause them to seek training from foreign-certificated flight instructors who use foreign-manufactured equipment and related training aides instead of FAA-certificated instructors using U.S.-manufactured equipment and related training aides.

Other commenters disagree with the proposed renewal requirement as a safety surveillance measure as it applies to airman certificates issued under parts 61 and 63. One commenter points out that the FAA's current biennial flight review and instrument competency checks fulfill the requirement for safety surveillance and that a proposed 24-month term for a new license would appear to be a duplication of the biennial flight review.

The FAA believes that although these comments have merit as they apply to certification under part 61, similar surveillance does not exist for airmen certificated under parts 63 and 65. This amendment would have ensured greater surveillance of operations involving U.S.-registered aircraft operating outside the United States. However, unless and until it is determined that foreign nationals should be required to demonstrate a need for certification on a periodic basis, the FAA does not believe it appropriate to institute the biennial renewal requirement. Therefore, the proposal is withdrawn at this time.

Other commenters point out that at many overseas locations served by U.S. air carriers there is no FAA-certificated repair station and that it is financially advantageous for U.S. air carriers to use resident foreign nationals who are FAA-certificated mechanics rather than incur the considerably higher costs of stationing FAA-certificated U.S. citizens at these locations. Finally, they indicate that many foreign nationals may find it difficult to pay the $400 fee for original airframe mechanic certification and be deterred from applying.

Current FAA-certificated mechanics will not be required to pay the fee for a mechanic certificate or the fee for an inspection authorization certificate. While the costs of initial certification of new applicants may have to be borne directly or indirectly by the U.S. employer, the potential cost on U.S. air carriers is minimal when compared to either their total overseas maintenance costs or the costs of stationing FAA-certificated U.S. citizens overseas. Furthermore, the need for cost recovery and fiscal responsibility in government far outweighs this impact.

The FAA also considered the possibility that U.S. citizens, such as those providing humanitarian or religious services in remote overseas locations, could be impacted negatively if these proposed fees deter foreign nationals from applying for original FAA mechanic certificates. The FAA does not expect foreign nationals to be deterred from applying. The employment value of certification to the foreign mechanic far outweighs the cost of this fee, and the value of the services provided U.S. citizens far outweighs whatever small percentage of the certification cost is passed on to them. Moreover, many of these U.S. citizens are already required to register their aircraft with the Civil Aviation Authority in the country in which it is based and therefore would be unaffected by the rule.

Issuance of Medical Certificates

Notice 81–12 proposed an $8 fee for the initial issuance of FAA medical certificates. Internal FAA review has shown that administering this separate fee for medical certificates would create an excessive burden by requiring the FAA to monitor the fee collection activities of overseas designated aviation medical examiners (AME's). To avoid this problem, applicants for initial student pilot certificates issued by the FAA or by a Designated FAA Examiner will pay a single fee for airman certification which will include $8 to cover the costs of a medical certificate issued under part 67. An $8 charge will also be included into the fee for an initial certificate issued under §§ 61.75, 61.77, 63.23, and 63.42 if the applicant presents such a medical certificate as evidence of meeting the medical standards for the foreign certificate upon which the application is based.

In keeping with the decision to remove any fee collection responsibility from AME's overseas applications for students pilot certificates must now be made directly to an FAA Flight Standards Office or to a Designated FAA Examiner and cannot be made to an AME. The administrative procedures of

§ 61.85 governing applications for student pilot certificates therefore have been amended to cover only applications made within the United States.

The Amendment

Accordingly, parts 61, 63, 65, 67, 145, and 187 of the Federal Aviation Regulations (14 CFR parts 61, 63, 65, 67, 145, and 187) are amended effective October 18, 1982.

(Secs. 313, 601, 602, Federal Aviation Act of 1958, as amended (49 U.S.C. 1354, 1421, and 1422); sec. 6(c), Department of Transportation Act (49 U.S.C. 1655(c)); Title V, Independent Offices Appropriations Act of 1952 (31 U.S.C. 483(a)); Sec. 28, International Air Transportation Competition Act of 1979 (49 U.S.C. 1159(b)).)

NOTE: Since compliance with these amendments will have only a minimal cost impact on the maintenance of U.S.-registered aircraft overseas and will not otherwise impose any cost or other economic burden on U.S. citizens, it has been determined that they are not major regulations under Executive Order 12291 and, for the same reason, it is certified that, under the criteria of the Regulatory Flexibility Act, they will not have a significant economic impact on a substantial number of small entities. The FAA has determined that this document involves regulations which are not significant under the Department of Transportation Regulatory Policies and Procedures (44 FR 11034; February 26, 1979). In addition, the FAA has determined that the expected impact on U.S. citizens of the regulations is no minimal that they do not require an evaluation.

Amendment 67–13

Organizational Changes and Delegations of Authority

Adopted: September 15, 1989 **Effective: October 25, 1989**

(Published in 54 FR 39288, September 25, 1989)

SUMMARY: This amendment adopts changes to office titles and certain terminology in the regulations that were affected by a recent agencywide reorganization. These changes are being made to reflect delegations of authority that were changed, as well as offices that were renamed or abolished and replaced with new office designations. These changes are necessary to make the regulations consistent with the current agency structure.

FOR FURTHER INFORMATION CONTACT: Jean Casciano, Office of Rulemaking (ARM–1), Federal Aviation Administration, 800 Independence Ave., SW., Washington, DC 20591; telephone (202) 267–9683.

SUPPLEMENTARY INFORMATION

Background

On July 1, 1988, the FAA underwent a far-reaching reorganization that affected both headquarters and regional offices. The most significant change is that certain Regional Divisions and Offices, which formerly reported to the Regional Director, are now under ''straight line'' authority, meaning that these units within each Regional Office report to the appropriate Associate Administrator (or Chief Counsel) in charge of the function performed by that unit.

Within part 11 of the Federal Aviation Regulations (FAR), various elements of the FAA have been delegated rulemaking authority by the Administrator. These delegations need to be updated. In addition, throughout the Federal Aviation Regulations references are made to offices that have been renamed or are no longer in existence as a result of reorganization.

Title 14 of the Code of Federal Regulations must therefore be amended to reflect the reorganizations and changes that have taken place.

Paperwork Reduction Act

The paperwork requirements in sections being amended by this document have already been approved. There will be no increase or decrease in paperwork requirements as a result of these amendments, since the changes are completely editorial in nature.

Good Cause Justification for Immediate Adoption

The amendment is needed to avoid possible confusion about the FAA reorganization and to hasten the effective implementation of the reorganization. In view of the need to expedite these changes, and because the amendment is editorial in nature and would impose no additional burden on the public, I find that notice and opportunity for public comment adopting this amendment is unnecessary.

Federalism Implications

The regulations adopted herein will not have substantial direct effects on the states, on the relationship between the National government and the states, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Conclusion

The FAA has determined that this document involves an amendment that imposes no additional burden on any person. Accordingly, it has been determined that: The action does not involve a major rule under Executive Order 12291; it is not significant under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and because it is of editorial nature, no impact is expected to result and a full regulatory evaluation is not required. In addition, the FAA certifies that this amendment will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The Rule

In consideration of the foregoing, the Federal Aviation Administration amends the Federal Aviation Regulations (14 CFR Chapter I) effective October 25, 1989.

The authority citation for part 67 continues to read as follows:

Authority: Secs. 313(a), 314, 601, 607, 72 Stat. 752; 49 U.S.C. 1354(a), 1355, 1421, and 1427.

Amendment 67–14

Pilots Convicted of Alcohol- or Drug-Related Motor Vehicle Offenses or Subject to State Motor Vehicle Administrative Procedures

Adopted: July 26, 1990 **Effective: November 29, 1990**

(Published in 55 FR 31300, August 1, 1990)

SUMMARY: This final rule sets forth regulations under which the FAA may deny an application for, and suspend or revoke, an airman certificate or rating if an individual has had two or more alcohol- or drug-related motor vehicle convictions or state motor vehicle administrative actions within a 3-year period (motor vehicle actions). The rule requires pilots to report to the FAA in Oklahoma City, Oklahoma, all alcohol- or drug-related motor vehicle convictions or state motor vehicle administrative actions that occur after the effective date of the final rule. The rule also amends the FAA's medical certification rules to include an ''express consent'' provision that authorizes the FAA to obtain information from the National Driver Register.

The rule is needed to prohibit a pilot from operating an aircraft after multiple alcohol- or drug-related motor vehicle actions. It is also needed to verify traffic conviction information required to be reported on the airman medical application and to evaluate whether the airman meets the minimum standards to be issued an airman medical certificate. The rule is intended to enhance safety in air travel and air commerce, and is necessary to remove from navigable airspace pilots who demonstrate an unwillingness or inability to comply with certain safety regulations and to assist in the identification of personnel who do not meet the medical standards of the regulations.

FOR FURTHER INFORMATION CONTACT: Mr. Robert Covell, Investigations and Security Division (ACS–310), Office of Civil Aviation Security, Federal Aviation Administration, 800 Independence Avenue, SW., Washington, DC 20591; telephone (202) 267–3965.

SUPPLEMENTARY INFORMATION:

Background

General Statement

The Federal Aviation Regulations (FAR) have addressed the issues of alcohol and drug use by an aircraft crewmember for many years. Section 91.11 of the FAR, for example, provides for certificate action against a person who acts, or attempts to act, as a crewmember of a civil aircraft within 8 hours after consumption of an alcoholic beverage; while under the influence of alcohol; while using any drug that affects the person's faculties in any way contrary to safety; or while having 0.04 percent by weight or more alcohol in the blood. Moreover, the FAA's strong interest in ensuring that airmen are not alcohol or drug dependent is demonstrated by the medical standards contained in part 67. This rule will supplement, not replace, the current regulations. It is intended to implement measures to further ensure the safety of air commerce. This will be accomplished by identifying and removing from airspace those persons who may commit unsafe acts in an aircraft because of a disregard for certain safety regulations; by identifying those persons who fail to report violations of specific safety regulations to the FAA as required; and by providing a means for verification of information or omission of information required to be reported on the application for airman medical certification.

Regulatory History

The FAA issued a notice of proposed rulemaking (NPRM) concerning pilots convicted of alcohol- or drug-related motor vehicle offenses or subject to state motor vehicle administrative procedures on May 11, 1989 (54 FR 21580; May 18, 1989). This NPRM was issued in part to respond to the results of an audit of the FAA's airman medical certification program by the Office of the Inspector General (OIG) of the U.S. Department of Transportation (DOT) released on February 17, 1987. The OIG evaluated the procedures used by the FAA to determine if pilots applying for medical certification had reported alcohol- or drug-related motor vehicle convictions on the FAA medical application form. This information and other historical data are required of applicants for medical certification to assist the agency in determining their physical and psychological fitness to safely operate an aircraft.

The OIG used three automated files to conduct its audit: (1) An extract from a state driver licensing file on alcohol- and drug-related motor vehicle offenses; (2) an extract from the National Driver Register (NDR); and (3) the FAA's airman medical file (the Automated Medical Certification Data Base). The OIG used these files to perform two comparisons for the audit. First, the OIG compared the FAA's medical file and the state records of alcohol- and drug-related traffic offenses. This comparison showed that 1,584 of the active pilots (3.4 percent) who held a driver's license issued by the state had at least one driving-while-intoxicated (DWI) or driving-under-the influence (DUI) conviction. Of these pilots, 1,124 pilots (71 percent) did not report this information to the FAA.

The OIG also compared the FAA's medical file with the NDR records for individuals whose driver's licenses had been suspended or revoked based on alcohol- or drug-related traffic offenses. This comparison disclosed that the driver licenses of approximately 1,300 of the 711,648 active airmen (1.45 percent) had been suspended or revoked for DWI or DUI offenses within the past seven years. Of these pilots 7,850 pilots (76 percent) failed to report these motor vehicle convictions to the FAA on their medical applications. The National Driver Register Act of 1982 (NDR Act) contains statutory restrictions regarding access and use of NDR information. Thus, the OIG collected only statistical data from the NDR and did not obtain the names of specific airmen during the audit.

After the audit report was released, the OIG announced its intention to conduct two computer matches as part of an investigative effort to gather specific, detailed information (52 FR 5374; February 20, 1987) (52 FR 8545; March 18, 1987). For the first match, the OIG matched the FAA's airman medical file with certain identification records of criminal history information of the Federal Bureau of Investigation (FBI). For the second match, the OIG matched FAA's Automated Medical Certification Data Base with the State of Florida Department of Highway Safety and Motor Vehicle driver licensing records for alcohol- or drug-related traffic offenses. These one-time computer matches resulted in the identification of specific airmen who allegedly falsified applications for medical certificates by failing to report alcohol- or drug-related convictions.

The OIG reported the results of the Florida state match and the Department of Justice (DOJ) match to the FAA for possible administrative action and to the DOJ for possible criminal action based on a violation of 18 U.S.C. 1001 for intentional falsification of an application for a medical certificate.

Based on the information discovered during the audit, the OIG recommended that the FAA develop an objective, regulatory standard that would provide the FAA certificate action against pilots convicted of alcohol- or drug-related motor vehicle offenses. The OIG also recommended that the FAA seek legislative changes to the NDR statute that would give the FAA access to NDR information. The National Transpor-

tation Safety Board (NTSB) and the U.S. General Accounting Office (GAO) supported these recommendations. On December 30, 1987, the President signed legislation amending the NDR Act to add section 206(b)(3) (Pub. L. 100–223; 101 Stat. 1525). In part, that statutory amendment authorizes the FAA to receive information from the NDR regarding motor vehicle actions that pertain to any individual who has applied for an airman medical certificate.

The amendment to the NDR Act states:

> Any individual who has applied for or received an airman's certificate may request the chief driver licensing official of a State to transmit information regarding the individual . . . to the Administrator of the Federal Aviation Administration. The Administrator of the Federal Aviation Administration may receive such information and shall make such information available to the individual for review and written comment. The Administrator shall not otherwise divulge or use such information, except to verify information required to be reported to the Administrator by an airman applying for an airman medical certificate and to evaluate whether the airman meets the minimum standards as prescribed by the Administrator to be issued an airman medical certificate. There shall be no access to information in the Register under this paragraph if such information was entered in the Register more than 3 years before the date of such request, unless such information relates to revocations or suspensions which are still in effect on the date of the request.'' [23 U.S.C. 401 NOTE]

On October 22, 1987, the FAA issued a notice (52 FR 41557; October 29, 1987) of a special enforcement policy regarding applicants for a medical certificate who have provided incorrect information about traffic convictions on a medical application form. In order to encourage compliance with the reporting requirement on the medical certificate application form, and to ensure that the FAA's records are accurate and complete, the FAA afforded airmen an opportunity to avoid FAA enforcement action based on falsification of their medical certificate application if they volunteered the corrected information to the FAA before January 1, 1988. As of that date, the FAA may take enforcement action, based on falsification of the medical certificate application, against those persons who had not provided corrected information. This includes those persons identified and referred by the OIG and those persons discovered through the FAA investigative process. However, even after January 1, 1988, the determined not to take enforcement action against those persons who submitted corrected information prior to the FAA obtaining that information from other sources. On October 27, 1988, the FAA issued a notice announcing complete termination of this so-called ''amnesty'' policy, effective December 1, 1988 (53 FR 44166; November 1, 1988). Therefore, after November 30, 1988, voluntary submission of corrected information does not preclude FAA enforcement action.

The FAA received about 11,300 letters from pilots disclosing offenses previously unreported on their medical application forms in response to the October 1987 notice. The ''disclosure'' letters served in most cases to secure amnesty from FAA enforcement action for these airmen as related to the falsification issue. The disclosures, however, did not preclude the FAA from denying an application or suspending or revoking a medical certificate, as appropriate, after evaluating the disclosures and determining tat an airman was medically not qualified.

Airmen whose traffic offenses suggested the need for further medical evaluation were asked to provide the agency with all court or administrative records associated with the offenses, or records associated with any care or treatment for substance abuse or related disorders. They also were asked to undergo specialized medical evaluations, if appropriate. The airman medical files of the individuals who submitted the information were updated and reevaluated in light of the new of information to ascertain whether those airmen continued to be medically qualified to operate an aircraft in a safe manner.

Since October of 1987, the FAA has reviewed approximately 24,000 airman medical files as a result of letters from pilots disclosing offenses previously unreported and of new applications for medical certificates indicating DWI or DUI convictions. The majority of the pilots whose files were reviewed were sent letters confirming their continued eligibility to hold medical certificates. Of the 24,000 airmen, approximately 2,400 (10 percent), were requested to submit additional information. Of this 2,400 airmen, an estimated 24 (1 percent) were denied medical certificates or had their medical certification suspended or revoked.

On April 11, 1989, the FAA issued another notice of enforcement policy (54 FR 15144; April 14, 1989). This notice announced the FAA's enforcement policy in those OIG-referred cases in which the airman had not come forwarded to disclose the convictions pursuant to the amnesty policy, as well as in similar cases which otherwise may come to the FAA's attention. In all cases, the FAA reviews the individual's medical eligibility, and take action, if appropriate, whether or not the FAA takes certificate action based on falsification.

Discussion of Comments

General Statement

The FAA received 84 timely comments in response to the May 18, 1989, NPRM. Based on its analysis and review of these public comments, the FAA is adopting some of the proposed revisions to parts 61 and 67, with changes as described. A discussion of the comments follows.

In general, the majority of the comments support the safety goal of the proposed rule. Those objecting say that the methods proposed by the FAA in the NPRM do not contribute to a safer aviation community, but rather place serious regulatory burdens on those airmen who are law-abiding. Among the commenters are six organizations representing airline and pilot associations; on Federal agency, the NTSB; and seventy-seven individual members of the flying and non-flying public. The organizations include the Air Line Pilots Association (ALPA), The Aircraft Owners and Pilots Association (AOPA), the Experimental Aircraft Association (EAA), the Helicopter Association International (HAI), the National Air Transportation Association (NATA), and the National Business Aircraft Association, Inc. (NBAA).

Specific Comments

Existing Laws and Regulations

Nine commenters note that the FAA already has safety and enforcement regulations in existence. They believe the FAA should enforce rather than promulgate additional regulations. In the words of one respondent, ''[t]he rules of the road are not the same as the rules of the air . . . Alcohol is allowed up to a certain amount, while driving a car. In the case of operating an airplane, no alcohol at all is the regulation.''

The FAA agrees with the need to enforce existing safety regulations. Several commenters indicate that the rules dictating ''within 8 hours'' or ''under the influence'' are already in place and are designed to protect the public from intoxicated pilots; the agency devotes considerable resources to this purpose. However, the previously described OIG audit shows that although only a small percentage of the aviation community may be involved, there are airmen who do not comply with the existing reporting requirements. There also are some airmen who have a record of multiple convictions for DWI and DUI, indicating that not all pilots show an appropriate concern for critical highway safety requirements. It is these pilots who are the focus of the detection mechanisms established by this rule.

Lack of Supportive Evidence of Correlation

Of concern to twenty-six commenters, including all six organizations, is the lack of statistical data to support the proposals presented in the NPRM. They note the lack of a proven correlation between alcohol and drug convictions while driving a motor vehicle and alcohol- and drug-related accidents while flying an aircraft.

The FAA made no attempt to obscure the lack of evidence correlating alcohol- or drug-related motor vehicle actions with substance abuse-related accidents or incidents while operating an aircraft. The FAA notes, however, that from 1978 to 1987, 6.0 percent of general aviation pilots killed in aviation accidents had a blood alcohol level of 0.04 percent or more. During that same period, 11,213 people died in general aviation accidents. If the rule were to result in the saving of a few lives, the potential benefits of the rule would exceed its potential cost.

If, for example, 6.0 percent of average annual deaths in general aviation accidents occurred in circumstances where alcohol may have been a contributing factor and the rule were only 1 percent effective in preventing such accidental deaths, then the benefits of the rule (given the values currently ascribed to a statistical life) would exceed its potential costs. FAA believes, in fact, that the rule will be significantly more effective than 1 percent so that potential benefits are likely to significantly exceed costs.

Therefore, FAA needs to develop an objective, regulatory standard that will enable the agency to take certificate action against convicted of alcohol- or drug-related motor vehicle offenses. Similarly, the FAA has a clear safety basis for ensuring that an applicant for a medical certificate fully and accurately completes the application so that the individual can be evaluated in accordance with the medical standards.

In light of the FAA's statutory mandate to protect and enhance aviation safety, the FAA elects to adopt the majority of the proposals in the NPRM. The potential consequence to aviation safety and the public interest of individuals with a recent history of DWI or DUI offenses piloting aircraft is at least as serious as for those driving motor vehicles, a situation demonstrated daily on our nation's highways. The agency believes that an individual whose conduct results in multiple alcohol- or drug-

related motor vehicle actions within a 3-year period should be subject to enforcement action with the potential for removal from the flying environment.

Difference Between Piloting an Aircraft and Driving an Automobile

Numerous objections to the proposals in the NPRM assert that there is little or no relationship between the task of piloting an aircraft and driving an automobile. The commenters contend that training and the environment surrounding the operations of motor vehicles and aircraft are drastically different and should not be subject to similar regulations. The commenters state that pilots are carefully selected and subject to different medical requirements and training than those licensed solely to operate motor vehicles, and, therefore, cannot be so directly equated.

The FAA is well aware that there are differences in training for motor vehicle and aircraft operation. However, driving an automobile on our nation's roads requires some type of state medical examination, at a minimum an eye examination, as well as a statement of health from the applicant or driver. Commercial drivers usually undergo medical examinations while private automobile drivers usually must self-certify and take a vision test. Applicants must respond to questions concerning their prior driving records and medical status and must also demonstrate practical driving skills. These conditions have been an acceptable part of obtaining a driver's license for the vast majority of adult Americans who undergo this procedure regularly. Similar procedures are required for those choosing to pilot aircraft.

The FAA agrees with the commenters that a higher level of skill and care must be exercised by those piloting aircraft in the interest of the public. In comparison to driving, aviation-related errors in judgment can be more serious; there is potential for greater property damage; and a pilot, particularly when engaged in commercial aviation, is responsible for the safety of passengers as well as for others both in the air and on the ground.

Legal Concerns

Numerous commenters raise issues that they believe are legal in nature. Three commenters argue that the proposed regulations overstep FAA's statutory authority, which involves the safety of flying. They believe that FAA regulations should address only the act of flying while under the influence of alcohol or drugs.

The FAA does not agree with these commenters. Information about a person's driving record, including DWI and DUI offenses, has long been required as a part of the application process for airman medical certification. Moreover, the FAA believes that conduct outside the time actually spent flying can be relevant to a determination of a person's capability to pilot an aircraft. Multiple driving convictions or administrative actions involving alcohol or drugs have relevance to the issues of judgment, compliance disposition, and medical qualifications.

Twenty-three commenters, including three organizations, oppose the NPRM on the basis of its intrusive nature. They argue repeatedly that since there is no statistical evidence to support the linking of a pilot's past driving record with his or her potential for alcohol or drug use in the cockpit, very little relevance exists for requiring access to the records in the NDR. As a result, it is argued that such a requirement by the FAA is, by nature, an invasion of privacy. Several commenters say that until definite proof is presented linking the two types of operation, no justification exists for the proposals.

The FAA acknowledges that there may be an impact on the privacy of individuals by virtue of obtaining the information in the NDR, but the impact is neither large nor unwarranted. First, most information in the NDR is public record information from the participating states. Second, the medical application already requires an applicant to reveal his or her driving record. Therefore, accessing the information in the NDR should not result in developing any new information about the applicant. Third, Congress passed legislation explicitly granting the FAA the authority to receive information contained in the NDR. The legislation contains limitations that safeguard the privacy interests of individuals whose NDR records are disclosed to the FAA.

Regarding the express consent form to be attached to the medical application for use in obtaining NDR information, one commenter states that the FAA's obtaining ''express consent by a deliberate and knowing act of administrative extortion'' is without statutory authority. This commenter believes that it is inappropriate to withhold issuance of a medical certificate if a person refuses to give consent to access the NDR.

The FAA does not agree. Indeed, the statute granting the FAA authority to receive NDR information tied the use of the information specifically to the medical certification process. The statute provides that that information is to be used ''to verify information required to be reported to the Administrator by an airman applying for an airman medical certificate and to evaluate whether the airman meets the

minimum standards as prescribed by the Administrator to be issued an airman medical certificate.'' [23 U.S.C. 401 note]

Numerous commenters said that pilots' constitutional rights would be violated because there is no opportunity for a hearing or appeal following ''automatic'' certificate action for two DWI convictions.

The FAA does not agree. This rule provides that multiple motor vehicle actions against a person within a 3-year period are grounds for suspension or revocation of any certificate or rating issued to that person under part 61. There is no ''automatic certificate action.'' Rather, the FAA will initiate appropriate enforcement action, and the FAA's normal enforcement procedures will be followed. An airman will be afforded all of the procedural safeguards that are available generally in FAA certificate action proceedings. These proceedings could include notice of proposed certificate action and, possibly, a hearing before an administrative law judge, an appeal to the National Transportation Safety Board and, finally, judicial review of the determination.

Three commenters, including two organizations, state that retroactive enforcement is unfair. They note that pilots would have exercised more caution against receiving a DWI or DUI conviction if they had known such convictions might affect their pilots' licenses.

The FAA recognizes this concern. Under the proposed rule, at least one motor vehicle action would have had to occur after the effective date of the final rule. However, possible loss of an airman certificate is not the reason a person should comply with state laws related to alcohol or drug use in operation of a motor vehicle. Those alcohol- and drug-related highway safety laws should be adhered to because they are the law. The failure to comply has serious adverse consequences. Alcohol- and drug-related traffic accidents result in the deaths of thousands of Americans every year. While other traffic offenses may result in accidents, alcohol and drug impairment clearly pose the greatest threat and are the result of conscious decisions. Motor vehicle actions reflect a lack of safety awareness, a lack of good judgment, and an indifference to the adherence to established requirements of law. Nevertheless, the FAA recognizes that directly linking an individual's compliance disposition toward critical safety requirements in the driving context to possible certificate action against that individual's pilot certificate is a fundamental change. The FAA agrees that the correlation should be prospective and has so provided in this final rule. To the extent that the rule has a deterrent effect, resulting in a proper compliance attitude toward the FAR, the rule will have achieved its goal.

Ten commenters, including three organizations, suggest that, in the words of one individual, the ''rule is using a flawed base for its determinations'' because DWI or DUI convictions are based on substantially different state laws. These differences include varying permissible blood alcohol concentrations (BAC) and differing state procedures for those charged with DWI or DUI offenses. Therefore, these commenters argue that the proposed rule could not be applied equally to all airmen.

The FAA is aware of impairment level and procedural differences among the states. However, these differences in state laws and procedures, which are a part of our Federal system, are not a reason for inaction. Every person driving an automobile is required to obey the laws of the state in which the vehicle is being operated. The fact that state laws differ is not a defense to charges of violating a law, nor do state law differences undermine a rule that uses convictions or state administrative actions under those varying laws. In the NPRM, the FAA requested specific comments on whether to treat state judicial proceedings involving ''probation before judgment'' and ''deferred adjudication'' as a ''motor vehicle action'' even though these proceedings may not result in a permanent record of conviction. The FAA agrees with a commenter who recommends that procedures such as probation before judgment and deferred adjudication not be considered motor vehicle actions. Further evaluation is needed of the possible impact on state procedures of including judicial proceedings that do not result in a conviction as a motor vehicle action under the rule. As defined in the rule, a motor vehicle action is a conviction; license cancellation, suspension, or revocation; or the denial of an application for a license to operate a motor vehicle by a state for a cause related to the operation of a motor vehicle while intoxicated by alcohol or a drug, while impaired by alcohol or a drug, or while under the influence of alcohol or a drug.

Finally, two commenters, including one organization, note that the Federal Highway Administration (FHWA) regulations refer only to ''on duty'' alcohol-and drug-related motor vehicle actions. The FHWA rule initially was broader, and included off duty convictions for operating a vehicle under the influence of alcohol. These commenters refer to a judicial decision involving the initial rule, *Whalen v. Volpe,* 348 F. Supp. 1235 (D. Minn. 1972), in which the court concluded that the FHWA rule was arbitrary, capricious, and unreasonable. The court found an absence of any rational basis to conclude that there was a correlation between a conviction for drunken driving while in a private automobile and future conduct driving commercial vehicle. The decision was vacated later based on a stipulation and agreement entered into by the parties, *Whalen v. Volpe,* 379 F. Supp. 1143 (D. Minn. 1973), and FHWA engaged

in further rulemaking. These commenters do not believe that the FAA reasonably can proceed to a final rule in light of the Whalen case.

The FAA is not persuaded that the Whalen case precludes promulgating a final rule in this rulemaking. Since the decision was vacated it has no precedential value. Moreover, there are significant distinctions between the FHWA rule and that agency's statutory authority and the FAA's rule and its statutory authority. The FAA believes that the Whalen rationale is no longer persuasive and that there have been significant changes in the recognition of the dangers of driving while impaired by drugs or alcohol and the reasonable inferences that can be drawn from such conduct about a person's judgment and compliance disposition. The effects of substance abuse on the safety of transportation are clear and the courts have recognized the authority of government agencies to take action to prevent these effects. Therefore, the FAA is not persuaded that a court today would reach the same conclusion that was reached by the court in the *Whalen* case.

Self-Policing

Eighteen commenters, including two organizations, believe that only a small segment of the flying population abuses drugs or alcohol. The commenters argue that the overwhelming majority of the pilot population is already doing an excellent job of self-policing; thus this rule is unnecessary.

The FAA agrees that the majority of the pilot community complies with the regulations by self-policing. The FAA accepts, and has so stated, that only a small percentage of the airman population may be affected by the abuse of alcohol or drugs. However a single impaired or intoxicated pilot could cause extensive and wide-spread damage to the public through loss of life or property damage. The FAA believes that this regulation will encourage greater self-policing and intends it to be primarily corrective in nature, assisting the agency, through deterrence, in attaining its primary mission, that of aviation safety.

Enforcement

Nineteen commenters say that they believe the FAA has become irrationally harsh in its enforcement policy, not improving compliance, and damaging the FAA's credibility. They state that this rule is one more step in this onerous direction.

The FAA's compliance and enforcement programs have been modified recently. The opinions of the flying population, particularly general aviation pilots, have been taken into consideration in the agency's on-going effort to maintain a high level of safety. There will be continued insistence on total compliance with the rules and regulations that have made our aviation system as safe as it is. But agency responsibility to enforce the rules will not prevent the FAA from addressing the aviation community's concerns and enhancing the FAA's responsiveness to the users of the system. The goal is to be firm but fair. The FAA intends to use a number of tools, including good communications, training, education, counseling, and finally enforcement, to achieve the primary goal of safety.

The FAA has become aware that there is a good deal of misunderstanding about the enforcement process, leading to a sense of mistrust. Therefore the new enforcement procedures will be more flexible, with greater emphasis on promoting compliance through education and open communication. The FAA will consider the need for simplification in some of the regulations to enhance understanding and promote compliance.

Nevertheless, clear-cut violations of regulations and a lack of compliance disposition must be handled decisively in the interest of promoting safety, particularly in such safety-sensitive areas as alcohol and drug abuse. The FAA regards violations in these areas as serious and will continue to expect strict adherence to the regulations. As stated in a recent FAA notice of enforcement policy (54 FR 15144; April 14, 1989), failure to disclose DWI or DUI convictions when applying for an airman medical certificate may be a violation of § 67.20 of the FAR. In pertinent part, that section provides that no person may make or cause to be made any fraudulent or intentionally false statement on any application for an airman medical certificate; so doing is a basis for suspending or revoking any airman certificate or rating held by that person.

Persons who make false statements on an application for an airman medical certificate also may be criminally prosecuted under 18 U.S.C. 1001, which carries a fine of not more than $10,000 or a term of imprisonment for up to 5 years, or both. While the FAA refers cases for consideration, the Department of Justice determines whether to prosecute a person under this statute.

Punishment

Twenty-one individuals and two organizations provided comment on the allegedly punitive nature of this rule. Seven commenters and one organization believe that the regulation should be more stringent, to include such issues as suspension of a pilot's license for a single DWI conviction.

The FAA considered basing enforcement on a single-drug or alcohol-related motor vehicle action, but chose not to do so because there are existing procedures that call for the review of any medical application in which the applicant discloses a past motor vehicle action. This review could lead to further action resulting in the denial, suspension, or revocation of a medical certificate. This review takes place at the time of the initial submission of a medical application, and is performed by the Aviation Medical Examiner (AME), followed by an additional agency review. Regarding the falsification issue, there is an existing FAR (§ 67.20) governing the providing of accurate information to the FAA, and Federal legislation exists (18 U.S.C. 1001) to address the criminal aspect of providing false information.

On the other hand, 13 commenters objected to the NPRM, making the argument that the ''punishment'' resulting from this rule is harsh and excessive. An airman certificate is required of all pilots; in the case of professional pilots, suspension or revocation would deprive them of their livelihood. This treatment, according to the arguments of the commenters, is too severe in comparison to other industries.

The FAA agrees that certificate suspension or revocation is a severe action, but one that fits the seriousness of the violation involved. The intent of these regulations is primarily corrective in nature, and to achieve the FAA's mandate to ensure safety in aviation. Therefore, the FAA will take appropriate enforcement action where pilots have violated laws related to substance use or abuse while operating a motor vehicle.

One organization states that virtually every pilot subject to an alcohol-or drug-related motor vehicle action will challenge any prosecution to the fullest extent of the law. While the FAA has no reason to doubt the comment's assertion there are ample reasons to contest a DWI or DUI charge apart from the action being taken in this rule. The decision to challenge a criminal or administrative charge is an option available to any individual in our society. If a pilot's record is reviewed pursuant to § 61.15 for possible denial of an application for a certificate or a rating, or suspension or revocation of an existing airman certificate or a rating, it is because the pilot has violated an FAA regulation. The opportunity for due process, as always, is available both in a state's criminal and administrative proceedings and the FAA's administrative proceedings.

Medical Examination Form

As adopted, this rule amends § 61.15 to require a pilot to report to the agency's Civil Aviation Security Division in Oklahoma City each alcohol-or drug-related motor vehicle conviction or administrative action that occurs after the effective date of the rule. This reporting requirement is unrelated to the existing requirement that a pilot fully and completely answer all questions related to traffic and other convictions on an *Application for an Airman Medical Certificate or Airman Medical and Student Pilot Certificate,* FAA Form 8500–8. One commenter contends that this requirement to describe any previous record or convictions should not be necessary as he is ''. . . at a loss to see the relevance between an airman making an illegal U-turn and his/her medical history.

The FAA considers an airman's conviction history pertinent to the medical certification process. An Aviation Medical Examiner (AME) uses this information, combined with the physical examination findings, as an important diagnostic tool. A history of traffic or other convictions may indicate a medical problem or may lead to further inquiry regarding an applicant's medical qualifications. While an illegal U-turn conviction, in and of itself, may not alert an AME to a possible medical problem, multiple traffic convictions might. Any reportable conviction information, coupled with a DWI or DUI conviction, could raise a question as to the applicant's fitness to perform the duties or exercise the privileges of an airman certificate. Given all the information, an AME and the agency can more accurately assess a pattern of behavior that may be indicative of a personality disorder that has repeatedly manifested itself by overt acts and, thus, may warrant denial of an application for, or suspension or revocation of, an airman's medical certificate.

Another commenter states that nowhere on the FAA Form 8500–8 does the seriousness of failing to disclose convictions appear. The agency refers that commenter to the lower left-hand corner of the form which contains a notice describing penalties for falsification or failure to disclose the information required.

Still other commenters believe that the possibility of an applicant overlooking a question, or of making an error in his or her response, is compounded by placing the conviction information the FAA is seeking within a small area in the medical history section of the form.

Data released on February 17, 1987, based on an audit conducted over a 7-year period by the OIG, indicate that more than 98.5 percent of the pilot population with convictions to report have done so successfully using the current form. The FAA, however, recognizes the merit of the commenters' desire to improve FAA Form 8500–8 to achieve an even higher degree of compliance and clarity and, thus, to lessen the opportunity for error.

At this time, the FAA is revising the current form for consistency with the amendment to part 67 as adopted in this final rule. The express consent provision is added to the form and is placed above the space provided for the applicant's signature. This provision allows the FAA to receive information about the applicant that has been reported to the NDR.

Along with the addition of the express consent provision, the agency is taking the opportunity to incorporate those suggestions that it deems will enhance the appearance and clarity of the form. Changes, in part, include revising the instructions for filling out the form; increasing the type-size, where possible; moving the conviction items to a more prominent location within the medical history section; and updating the portion that deals with penalties for falsification. The agency believes that these revisions will enable more applicants for an airman medical certificate to provide the required information accurately and with less effort.

Rehabilitation and Education

Several commenters believe there should be provisions made for rehabilitation and education. According to the commenters, the time and effort which the FAA would spend with this program would be better spent in developing and encouraging rehabilitation programs. The FAA is described by the commenters as more concerned with taking punitive measures taken to remove the offending individuals from the aviation community than with taking a more humane, restorative approach of ''compassionate intervention and rehabilitation.''

The FAA accepts and endorses education and rehabilitation as important and necessary facets of any drug or alcohol program. In fact, the agency has an active and successful employee assistance program (EAP). The FAA encourages the creation and use of industry EAPs. The FAA also encourages individuals to seek help if they have a substance abuse problem. Community health organizations generally have programs to assist such individuals. However, the primary mission of the FAA is aviation safety and the identification of associated safety problems.

Paperwork Burden

Four commenters say that this regulation would cause an undue paperwork burden on the FAA.

There admittedly will be an increase in workload among the various offices responsible for implementation of this rule. However, the agency believes that the potential for increased safety in the aviation community justifies the additional burden. Every effort will be made, however, to reduce the burden of the agency's new recordkeeping requirements. For example, in revising the application for medical certification, FAA Form 8500–8, the NDR access express consent provision will be printed on the form itself, thus eliminating an extra document that must be retained by the FAA. A detailed listing of the reporting and recordkeeping requirements can be found in part IV of the Regulatory Evaluation which is contained in the docket.

Insufficient Reporting Time

Several respondents note that pilots should be given more than 60 days to report past alcohol- or drug-related driving convictions and administrative actions. They contend that 60 days from the effective date of the final rule does not allow sufficient time for a pilot to learn of the promulgation of the regulation and then to report past motor vehicle actions. One organization suggests pilots might find it necessary to contact state officials, determine the nature of certain prior state actions, and then seek counsel on whether reporting of a specific action is required under the regulations.

Although the NPRM proposed the reporting of each alcohol- or drug-related motor vehicle action received in the 3-year period prior to the rule, this provision is not being adopted. The final rule requires only reporting of alcohol- and drug-related motor vehicle convictions or state administrative actions received after the effective date of the rule. The notification of each motor vehicle action must be received by the agency within 60 days after the conviction or administrative action. Given the deletion of the requirement to report motor vehicle actions that occurred in the 3-year period prior to the effective date of the final rule, the FAA believes that the 60-day notification period is realistic and reasonable. In addition, the effective date of the final rule is 120 days after publication in the *Federal Register*. This fairly lengthy period should provide ample opportunity for the final rule requirements to be made widely known.

Proposed Amendment to § 61.23, Duration of Medical Certificates

The NPRM proposed amending § 61.23 by adding new paragraph (d) to change the duration of an airman medical certificate. The proposed amendment provided that any medical certificate would expire automatically on the 61st day after a pilot was convicted of, or a state had taken administrative action on, a single alcohol- or drug-related motor vehicle violation, unless the medical certificate would otherwise expire before the 61st day. The pilot could continue to operate an aircraft for 60 days after the date of conviction or until expiration of the certificate, if earlier, as long as the pilot was not otherwise disqualified under part 67. The pilot could schedule and complete a new medical examination anytime after the date of the motor vehicle action. If the pilot chose to reapply within 60 days after the conviction, and, if based on this examination and the agency's review of the conviction or administrative action, the pilot continued to meet the medical standards of part 67, then he or she would be issued a new medical certificate and could continue to pilot an aircraft without interruption.

In addition, the NPRM proposed in new paragraph (d)(1) that each applicant be required to present to the AME, at the time of application and medical examination for a new certificate, any documents that substantiated participation in any court-ordered substance abuse treatment plan, and in new paragraph (d)(2), that each subject applicant be required to show the AME evidence of compliance with any other court-ordered program related to the conviction, such as community-service.

Numerous commenters contend that no measure should be taken to deny an application for, or suspend or revoke, an airman's medical certificate for a single DWI or DUI conviction or action but, rather, the airman should continue to be required to report convictions on the medical application from as a basis for further medical evaluation. The commenters support the FAA's efforts to deny medical certification to airmen with disqualifying alcohol- or drug-related medical conditions, but argue that a medical diagnosis seems unlikely based solely on a single alcohol- or drug-related motor vehicle conviction or state administrative action. Still others question the premise that, based on a single DWI or DUI action, the agency would discover pilots with alcohol or drug problems. These commenters believe that if the agency considered this proposition likely, the proposed amendment to § 61.23 would not have been drafted to allow such individuals the latitude to continue to pilot an aircraft for up to 60 days without having to undergo a medical evaluation.

Some commenters have taken the FAA to task over the requirement in the proposed rule to have the AME evaluate court and other administrative records, presented by the examinee, to determine compliance with any court-ordered program related to a conviction. These court-imposed programs could vary from attendance in a substance-abuse treatment program to participation in a community service program. Other commenters, themselves physicians, also express grave reservations over this issue. They believe that the AME would be placed in the unfamiliar role of reviewer and verifier of legal documents, and would further have to attempt to determine if the sanctions imposed had been, or were being, discharged accordingly.

The FAA has considered the commenters' views regarding the likelihood of obtaining significant results from requiring a pilot to reapply for a medical certificate after a single motor vehicle action (DWI, DUI, or state administrative action). The agency agrees that only rarely would a medical examination triggered as a result of a single motor vehicle action provide a basis for a diagnosis of alcoholism or drug dependency. The additional examinations that would have been triggered by the proposed requirement would be a significant increase in workload to the agency and an expenditure of community medical resources; conservatively, the FAA estimates that 7,000 additional applications for medical certification would be processed annually. Also of consequence would be the fees to be paid by the airmen in compliance with the reexamination requirement. If the findings from the additional examinations prove minimal, as expected, then imposing these requirements appears to be unwarranted.

The FAA has further determined that the provisions as proposed in § 61.23(d)(2) are beyond the scope of Current AMEs' training or expertise. It is FAA policy that every DWI or DUI conviction or state motor vehicle administrative action noted on an application for an airman medical certificate be reviewed by the Aeromedical Certification Division of the Civil Aeromedical Institute (CAMI) for indications of a condition warranting denial of an application or suspension or revocation of a medical certificate. This includes an additional medical review when multiple motor vehicle actions are listed on an application for a medical certificate. Two motor vehicle actions within 3 years, as provided by new § 61.15(d), still will provide grounds for certificate action against a pilot's airman certificate apart from any additional medical review. Thus, after considering all the comments received, the FAA has not adopted in this final rule the proposed amendment to § 61.23.

Pursuant to new § 61.15, the agency requires that a pilot report each alcohol- or drug-related motor vehicle conviction or administrative action that occurs after the effective date of the rule to the Civil Aviation Security Division (CASD) in Oklahoma City. The report of a motor vehicle action will result

in a review of that pilot's medical file to determine if there is a basis for reconsideration of the individual's eligibility for medical certification.

The FAA is confident that the early identification mechanisms currently in place, the new reporting requirement, and the scheduled crosscheck of the airman medical records with the NDR, are sufficient to maintain the requisite high level of safety for the aviation community and the traveling public. Thus, the FAA has concluded that limiting the duration of a medical certificate after a single motor vehicle action is not warranted.

Costs

Four commenters, including one organization, raise economic issues. Three say that the administrative paperwork would not be ''nominal'' and that the FAA should attempt to quantify these costs. The FAA agrees, and has specified the step-by-step process, with the costs involved in each step, in Section IV of the Regulatory Evaluation.

Two of the commenters say that the loss of pilot employment or pay resulting from this rule should be considered as a cost of this rule. The FAA disagrees because this rule merely identifies those pilots already having received alcohol- or drug-related motor vehicle convictions or administrative actions. Any cost is related to these pilots' own actions rather than the FAA's actions.

One commenter notes that the FAA stated in the NPRM that the loss of employment is not a regulatory cost and ''that the proposed rules would not have a significant economic impact . . . on a substantial number of small entities.'' This commenter asked whether a pilot is considered a small entity. The quoted language is based on the Regulatory Flexibility Act of 1980 (RFA) and comes from the Regulatory Flexibility Determination section of the NPRM. The FAA is required to ensure that small entities are not unnecessarily and disproportionately burdened by Government regulations. The criteria for a ''substantial number of small entities'' is one-third of the small firms subject to the final rule, but no fewer than 11 firms. This commenter understood ''small entity'' to mean an individual pilot, instead of a small firm. A firm, regardless of size, is made up of employees. In this case, the small firm being referenced here is made up of pilots and other employees. The loss of employment for an individual pilot may or may not have a ''significant economic impact . . . on a substantial number of small entities.'' In this case, the FAA has determined that this rule would not have such an impact.

Section-By-Section Discussion of the Rules

Several changes from the NPRM language have been made in the final rule. Some differences are intended to improve clarity; others are of a more substantive nature.

§ 61.15 Offenses Involving Alcohol or Drugs

Section 61.15(c) of the final rule has been modified to reflect that only motor vehicle actions that occur after the effective date of the rule must be reported to the FAA. The proposed rule had referenced reporting responsibility in the pilot's recent past as well as after the effective date. Reporting alcohol- or drug-related convictions or state motor vehicle administrative actions in the recent past is not a requirement of the final rule. This change is also reflected in paragraphs (d) and (e).

A modification was made to § 61.15(d) of the final rule to reflect that multiple motor vehicle actions as defined in the rule resulting from the same driving incident or factual circumstances will be viewed as one motor vehicle action for purposes of § 61.15(d). However, a pilot still must report each action to the FAA, regardless of whether it arises out of the same driving incident or factual circumstance. As part of the pilot's description of the action, the pilot should note that the action being reported is part of a single set of factual circumstances and reference any prior action arising out of the same facts.

Section 61.15(e) of the final rule differs from the proposed rule in the address to which the information must be sent. This has been changed from the Airman Certification Branch to the Civil Aviation Security Division.

Section § 61.15(f)(1) of the final rule differs from the proposed rule § 61.15(e(1)) in one minor respect. The final rule provides that the denial of any application for a certificate for a 1-year period dates from ''the date of the last motor vehicle action'' as compared to the proposed rule language which states ''the date of the failure to report a motor vehicle action.''

§ 61.23 Duration of Medical Certificates

The NPRM proposed amending § 61.23 by adding a new paragraph (d) to change the duration of an airman's medical certificate. This requirement has not been adopted in the final rule.

§ 67.3 Access to the National Driver Register

Two minor changes were made to this section. First, the rule has been changed to clarify that a person desiring to review the NDR information must request that the Administrator make the information available. Second, additional language has been added to clarify that the consent authorizes the Administrator to request the chief driver licensing official of the state to transmit information contained in the NDR about the person to the Administrator. Finally, certain editorial changes in the final rule have been made for clarity.

Paperwork Reduction Act

Section 61.15(d) would require a pilot to report to the FAA each alcohol- or drug-related motor vehicle conviction and each alcohol- or drug-related state administrative action. Information collection requirements in the amendment to § 61.15(d) have been submitted for approval to the Office of Management and Budget (OMB) under the provisions of the Paperwork Reduction Act of 1980 (Pub. L. 96–511).

Regulatory Evaluation Summary

Executive Order 12291, dated February 17, 1981, directs Federal agencies to promulgate new regulations or modify existing regulations only if the potential benefits to society for the regulatory changes outweigh the potential costs to society. The order also requires the preparation of a Regulatory Impact Analysis of all ''major'' rules except those responding to emergency situations or other narrowly-defined exigencies. A ''major'' rule is one that is likely to result in an annual effect on the economy of $100 million or more, a major increase in consumer costs, or a significant adverse effect on competition.

This final rule is determined not to be ''major'' as defined in the Executive Order, therefore a full Regulatory Impact Analysis evaluating alternative approaches is not required. A more concise Regulatory Evaluation has been prepared, however, which includes an analysis of the economic consequences of the regulation. This analysis has been included in the docket, and quantifies, to the extent practical, estimated costs as well as the anticipated benefits, and impacts.

A summary of the Regulatory Evaluation is contained in this section. For a more detailed analysis, the reader is referred to the full Evaluation contained in the docket.

The final rule establishes a basis for the denial of an application for a pilot certificate and a basis for the revocation or suspension of a pilot certificate for pilots convicted of alcohol- or drug-related motor vehicle offenses or for pilots penalized as a result of state administrative action for cause. Under this final rule, a pilot must report to the FAA any conviction or administrative action that occurs after the effective date of the rule. Failure to report even one conviction or administrative action to the FAA is grounds for denial of an application for an airman certification and grounds for suspension or revocation of a certificate issued under part 61. This reporting requirement is distinct from the existing requirement to report traffic and other convictions on an application for an airman medical certificate.

The FAA's denial of an application and the suspension or revocation of an existing certificate will be based on two or more alcohol- or drug-related motor vehicle convictions, two or more administrative actions by a state for cause, or at least one conviction and one administrative action occurring within a 3-year period.

This final rule amends Section 61.15 of the Federal Aviation Regulations (FAR) and affects an estimated 752,000 individuals currently holding active medical certificate in conjunction with student, private, commercial, airline transport, glider-only, and lighter-than-air pilot certificates and ratings issued by the FAA. Promulgation of this final rule could result in the denial, revocation, or suspension of the privilege to operate an aircraft for an estimated 1,000 to 12,000 pilots annually. The costs of suspension or revocation of a certificate issued under part 61 will be the negative economic impact associated with the temporary or permanent loss of employment for pilots engaged in commercial aviation. The FAA does not consider this a cost of the rule; rather it considers these costs to be the result of alcohol or drug use in connection with the operation of a motor vehicle.

The FAA has calculated the present value cost of this rule to be $4,409,794, discounted over a 10-year period, in 1988 dollars. The vast bulk of these costs are internal FAA administrative costs and will not be borne by the individual pilots. The costs occurring in the first year are estimated to be $1,116,864, in the second year are estimated to be $670,765, and in each subsequent year are estimated to be $644,158.

The FAA has incorporated a consent provision in the FAA medical application form (Form 8500–8, the *Application for Airman Medical Certificate or the Airman Medical and Student Pilot Certificate)* for use in searching for alcohol- or drug-related convictions or administrative actions reported to the

National Driver Register (NDR). This consent will allow the FAA to query the NDR about every pilot who applies for an airman medical certificate.

Based on the requirements of the final rule, airmen will have 60 days to send a letter to the Civil Aviation Security Division (AAC–700) with their name, airman certificate number, and information about any DWI or DUI conviction or state administrative action acquired after the effective date of the rule.

Depending on the certificate held or the operations conducted, each pilot must have a physical examination every 6 months, 1 year, or 2 years; at that time, the following screening/checking process will begin for that pilot. An average of 10,000 pilots per week undergo FAA physicals. Thus, the FAA facility in Oklahoma City processes the 10,000 applications for medical certification per week. A tape with the pilot data will be sent each week, through the appropriate agencies, to the NDR. The NDR will match this tape against its register, and will create a tape of any pilot data entries that agree. This information will then be returned to the FAA, and will be used to obtain the necessary state driving records. The resulting data on the estimated 200 pilots per week will be compiled for comparison with medical history data and with the disclosures required for § 61.15.

The FAA expects that this rule will reduce the number of aviation accidents caused by pilots who may be impaired by alcohol or drugs during aircraft operations. However, the FAA has been unable to directly quantify the expected benefits of the final rule. Some observations can be made, however, regarding potential benefits. During the period from 1978 to 1987, 6.0 percent of general aviation pilots killed in aviation accidents had a blood alcohol level of at least 0.04 percent. During this same 10-year period, 11,213 people died in general aviation accidents. If 6.0 percent of these people died in accidents where the pilot was under the influence or impaired by alcohol, over 670 people died in accidents where alcohol may have been a contributing cause.

Based on this analysis, and using $4.4 million as the present value 10 year cost of the rule, the chart below shows the cost of saving one life as a function of the effectiveness of the rule in preventing accidents.

Effectiveness of rule (%)	Cost of Rule per life saved (Dollars)
1	$640,000
10	64,000
20	32,000
30	21,300
40	16,000
50	12,800
60	10,700
70	9,000
80	8,000
90	7,100
100	6,400

At this time, the FAA cannot accurately predict how effective the rule will be in preventing fatalities such as discussed above. Even if it proves to be only one percent effective, however, the cost per fatality prevented appears to be less than values currently ascribed to a statistical life. The FAA believes that the rule will be more effective than one percent and concludes that the potential benefits of the rule will exceed potential costs.

Four commenters raise economic issues based on the cost/benefit analysis in the Notice of Proposed Rulemaking (NPRM). A discussion of these comments is contained in the final Regulatory Evaluation contained in the docket and elsewhere in the preamble to the rule.

Regulatory Flexibility Determination

The Regulatory Flexibility Act of 1980 (RFA) was enacted by Congress to ensure that small entities are not unnecessarily and disproportionately burdened by Government regulations. The RFA requires Federal agencies to review rules which may have a ''significant economic impact on a substantial number of small entities.''

The FAA's criterion for a ''substantial number'' are a number which is not less than 11 and which is more than one third of the small entities subject to the rule. For air carriers, a small entity has been defined as one who owns, but does not necessarily operate, 9 or less aircraft. The FAA's criterion for a ''significant impact'' are at least $3,800 per year for an unscheduled carrier, $53,500 for a scheduled

carrier having an airplane or airplanes with only 60 or fewer seats, and $95,800 per year for a scheduled carrier having an airplane with 61 or more seats.

The FAA has determined that the rule will not have a significant economic impact, positive or negative, on a substantial number of small entities. The basis of this determination is the FAA's opinion that any adverse economic consequences associated with the loss of the privilege to operate an aircraft for aviation pilots convicted of alcohol- or drug-related motor vehicle offenses or penalized as a result of state administrative action for cause is the direct consequence of alcohol or drug use in connection with the operation of a motor vehicle and not as a result of the rule. Since there are minimal economic consequences due to the rule, the total costs that could be attributable to a significant number of small entities are below the threshold dollar limits.

Trade Impact Statement

This final rule will affect only those individuals who hold an FAA-issued airman certificate and, therefore, would have no impact on trade opportunities for U.S. firms doing business overseas or foreign firms doing business in the United States.

Federalism Implications

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this regulation would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Conclusion

For the reasons discussed in the preamble, and based on the findings in the Regulatory Flexibility Determination and the International Trade Impact Analysis, the FAA has determined that this regulation is not a major regulation under the criteria of Executive Order 12291. In addition, the FAA certifies that this regulation will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. This regulation is considered significant under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979). A regulatory evaluation of the regulation, including a Regulatory Flexibility Determination and International Trade Impact Analysis, has been placed in the docket. A copy may be obtained by contacting the person identified under ''FOR FURTHER INFORMATION CONTACT.''

The Amendments

In consideration of the foregoing, the Federal Aviation Administration amends part 61 and part 67 of the Federal Aviation Regulations (14 CFR parts 61 and 67) effective November 29, 1990.

The authority citation for part 67 is revised to read as follows:

Authority: 49 U.S.C. app. 1354(a), 1355, 1421, and 1427; 49 U.S.C. 106(g) (Revised Pub. L. 97–449, January 12, 1983).

Amendment 67–15

Medical Standards and Certification

Adopted: September 1, 1994 **Effective: September 9, 1994**

(Published in 59 FR 46706, September 9, 1994)

SUMMARY: This final rule restates the general medical condition standards for first-, second-, and third-class airman medical certificates. In determining an applicant's eligibility for medical certification, the FAA's longstanding policy and practice have been to consider an applicant's medication and other treatment under the general medical conditions standards. In a recent decision by the U.S. Court of Appeals for the Seventh Circuit, however, the court found that the general medical condition standards cannot be interpreted to provide a basis for disqualification due to medication alone. This emergency final rule is, therefore, necessary to restate the general medical condition standards for an individual whose medication or other treatment makes or is expected to make that individual unable to safely perform the duties or exercise the privileges of an airman certificate.

DATES: Effective September 9, 1994. Comments must be received by November 7, 1994.

ADDRESSES: Comments on this rule should be mailed or delivered, in triplicate, to: Federal Aviation Administration, Office of the Chief Counsel, Attention: Rules Docket (AGC–200), Docket No. 27890, 800 Independence Avenue, SW., Washington, DC 20591. Comments mailed or delivered must be marked Docket No. 27890. Comments may be examined in room 915G weekdays, except on Federal holidays, between 8:30 a.m. and 5 pm.

FOR FURTHER INFORMATION CONTACT: Dennis P. McEachen, Manager, Aeromedical Standards and Substance Abuse Branch (AAM–210), Office of Aviation Medicine, Federal Aviation Administration, 800 Independence Avenue, SW., Washington, DC 20591; telephone (202) 493–4075; telefax (202) 267–5399.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to comment on this final rule by submitting such written data, views, or arguments as they may desire. Comments relating to the environmental, energy, federalism, or economic impact that might result from adopting this amendment are also invited. Substantive comments should be accompanied by cost estimates. Comments must identify the regulatory docket number and should be submitted in triplicate to the Rules Docket address specified above. All comments received on or before the specified closing date for comments will be considered by the Administrator. This rule may be amended in consideration of comments received.

Background

Part 67 of Title 14 of the Code of Federal Regulations (14 CFR part 67) details the standards for the three classes of airman medical certificates. A first-class medical certificate is required to exercise the privileges of an airline transport pilot certificate, while second- and third-class medical certificates are required to exercise the privileges of commercial and private pilot certificates, respectively. An applicant who is found to meet the appropriate medical standards, based on medical examination and evaluation of the applicant's history and condition, is entitled to a medical certificate without restrictions other than the limit of its duration prescribed in the regulations.

Paragraph (f)(2) of §§ 67.13, 67.15, and 67.17 is the standard for determining an applicant's eligibility for first-, second-, and third-class medical certification based on general medical conditions. Specifically, under paragraph (f)(2), an applicant is ineligible for unrestricted medical certification if he or she has an organic, functional, or structural disease, defect, or limitation that the Federal Air Surgeon finds: (1) makes the applicant unable to safely perform the duties or exercise the privileges of the airman certificate the applicant holds or for which the applicant is applying or (2) may reasonably be expected within 2 years of the Federal Air Surgeon's finding to make the applicant unable to safely perform those duties or exercise those privileges. The Federal Air Surgeon's finding must be based on the applicant's case history and appropriate, qualified, medical judgment relating to the condition involved.

Paragraph (f)(2) long has been the basis for denying medical certification in cases where the Federal Air Surgeon has determined that an applicant's medication or other treatment (including prescription, over-the-counter, and nontraditional medication or other treatment remedies) interfere with the applicant's ability to safely perform the duties or exercise the privileges of the airman certificate for which the airman is applying or holds. The medication or other treatment may or may not be associated with an underlying medical condition that would be disqualifying for medical certification. For example, a hypnotic medication, such as a benzodiazepine, may be prescribed to treat a condition such as recurrent insomnia. Recurrent insomnia, depending on the circumstances, may not preclude eligibility for medical certification. The medication used to treat the condition, however, has potential adverse effects, such as dizziness, drowsiness, ataxia, and ''hangover.'' Exposure to such a medication could unpredictably interfere with the applicant's ability to safely perform the duties or exercise the privileges of the airman certificate held or applied for, posing a hazard to the applicant and to public safety.

Other medications have potential adverse effects that can occur with unpredictable frequency, duration, or severity. These adverse effects can be numerous and can include such conditions as cardiac arrhythmia, hypotension, over-sedation, and akathesia. Each of these effects may be inconsistent with aviation safety. In addition, some forms of treatment (e.g., surgery, radiation therapy, chemotherapy, and hemodialysis) have adverse effects that can interfere with an airman's ability to safely perform the duties or exercise the privileges of an airman certificate. The Federal Air Surgeon considers relevant factors on a case-

by-case basis, including potential adverse effects, to determine whether the medication or other treatment received by an airman is inconsistent with medical certification.

Notwithstanding the FAA's longstanding medical certification policy and practice under paragraph (f)(2) regarding medication and other treatment, the U.S. Court of Appeals for the Seventh Circuit recently determined that paragraph (f)(2) does not provide a basis for denial of medical certification based on medication alone. *Bullwinkel* v. *Fed. Aviation Admin.,* No. 93–1803 (7th Cir., Apr. 27, 1994), *reh'g. denied.* 1994 U.S. App. LEXIS 15779 (June 23, 1994). The *Bullwinkel* case involved the use of lithium. The focus of the Seventh Circuit's decision was not on the safety concerns that lithium use poses; instead, the court centered its attention on interpreting the specific language of the regulation. Although the court's decision concerned the airman's use of a medication, its rationale could apply to other forms of treatment as well.

The FAA disagrees with the Seventh Circuit's narrow reading of paragraph (f)(2) in the *Bullwinkel* case. However, regardless of the merits of the respective positions on how to interpret paragraph (f)(2), the Seventh Circuit's decision raises serious safety concerns that require the immediate adoption of an amendment that expressly states the FAA's authority to disqualify an individual who holds or is applying for an airman medical certificate in cases where medication or other treatment may interfere with that individual's ability to safely perform airman duties.

This final rule amends paragraph (f) of §§ 67.13, 67.15, and 67.17 by adding new paragraph (f)(3). New paragraph (f)(3) sets out the standard for certification where medication or other treatment is involved. Paragraph (f)(3) makes ineligible for unrestricted medical certification any applicant whose medication or other treatment the Federal Air Surgeon finds makes, or may reasonably be expected to make within 2 years after the finding, that applicant unable to safely perform the duties or exercise the privileges of an airman certificate. This final rule does not change the FAA's current and longstanding application of the certification standards. Rather its sole purpose is to expressly state the agency's practice in light of the *Bullwinkel* decision.

Also, for continuation of the current administration of medical certification procedures, reference to this emergency final rule is added by revising § 67.25, Delegation of authority, and § 67.27, Denial of medical certificate.

Good Cause Justification for Immediate Adoption

This amendment is being adopted without notice and a prior public comment period because delay in adoption could have a significant adverse effect on aviation safety, and because the amendment effects no change in well established agency application of the medical certification standards.

Therefore, the FAA finds that: (1) an emergency situation exists requiring the immediate adoption of this amendment; (2) the publication of a notice of proposed rulemaking with its opportunity for public comment is impracticable; and, (3) good cause exists for amendment in less than 30 days.

Paperwork Reduction Act

In accordance with the Paperwork Reduction Act of 1980 (Pub. L. 96–511), there are no requirements for information collection associated with this rule.

Regulatory Flexibility Determination

The Regulatory Flexibility Act of 1980 (RFA) was enacted by Congress to ensure that small entities are not unnecessarily or disproportionately burdened by Government regulations. The RFA requires a Regulatory Flexibility Analysis if a rule would have a significant economic impact, either detrimental or beneficial, on a substantial number of small entities. FAA Order 2100.14A, Regulatory Flexibility Criteria and Guidance, provides threshold cost and small entity size standards for complying with RFA review requirements in FAA rulemaking actions. After reviewing the projected effects of the rule in light of these standards, the FAA finds that the rule would not have significant economic impact on a substantial number of small entities.

International Trade Impact Statement

The rule would have little or no impact on trade for both U.S. firms doing business in foreign countries and foreign firms doing business in the United States.

Federalism Implications

The rule adopted herein will not have substantial direct effects on the states, on the relationship between the Federal government and the states, or on the distribution of power and responsibilities among

the various levels of government. Therefore, in accordance with Executive Order 12866, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

International Civil Aviation Organization (ICAO) and Joint Aviation Regulations

In keeping with U.S. obligations under the Convention on International Civil Aviation, it is FAA policy to comply with ICAO Standards and Recommended Practices to the maximum extent practicable. The FAA has determined that this rule does not conflict with any international agreement of the United States.

Conclusion

The FAA has determined that this final rule is an emergency rule that must be issued immediately to correct an unsafe condition. Based on the findings in the Regulatory Flexibility Determination and the International Trade Impact Analysis, the FAA has determined that this final rule will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. This final rule is not considered significant under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979).

The Amendment

In consideration of the foregoing, the FAA amends part 67 of Title 14 of the Code of Federal Regulations effective September 9, 1994.

The authority citation for part 67 continues to read as follows:

Authority: 49 U.S.C. app. 1354, 1355, 1421, 1422, and 1427; 49 U.S.C. 106(g).

Amendment 67–16

Revision of Authority Citations

Adopted: December 20, 1995 **Effective: December 28, 1995**

(Published in 60 FR 67254, December 28, 1995)

SUMMARY: This rule adopts new authority citations for Chapter I of Title 14 of the Code of Federal Regulations (CFR). In 1994, the Federal Aviation Act of 1958 and several other statutes conferring authority upon the Federal Aviation Administration were recodified into positive law. This document updates the authority citations listed in the Code of Federal Regulations to reference the current law.

DATES: This final rule is effective December 28, 1995. Comments on this final rule must be received by March 1, 1996.

FOR FURTHER INFORMATION CONTACT: Karen Petronis, Office of the Chief Counsel, Regulations Division (AGC–210), Federal Aviation Administration, 800 Independence Ave., SW., Washington, DC 20591; telephone (202) 267–3073.

SUPPLEMENTARY INFORMATION: In July 1994, the Federal Aviation Act of 1958 and numerous other pieces of legislation affecting transportation in general were recodified. The statutory material became ''positive law'' and was recodified at 49 U.S.C. 1101 *et seq.*

The Federal Aviation Administration is amending the authority citations for its regulations in Chapter I of 14 CFR to reflect the recodification of its statutory authority. No substantive change was intended to any statutory authority by the recodification, and no substantive change is introduced to any regulation by this change.

Although this action is in the form of a final rule and was not preceded by notice and an opportunity for public comment, comments are invited on this action. Interested persons are invited to comment by submitting such written data, views, or arguments as they may desire by March 1, 1996. Comments should identify the rules docket number (Docket No. 28417) and be submitted to the address specified under the caption ''FOR FURTHER INFORMATION CONTACT.''

Because of the editorial nature of this change, it has been determined that prior notice is unnecessary under the Administrative Procedure Act. It has also been determined that this final rule is not a ''significant regulatory action'' under Executive Order 12866, nor is it a significant action under DOT regulatory policies and procedures (44 FR 11034, February 26, 1979). Further, the editorial nature of this change has no known or anticipated economic impact; accordingly, no regulatory analysis has been prepared.

Adoption of the Amendment

In consideration of the forgoing, the Federal Aviation Administration amends 14 CFR Chapter I effective December 28, 1995.

The authority citation for part 67 is revised to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701–44703, 44707, 44709–44711, 45102–45103, 45301–45303.

Amendment 67–17

Revision of Airman Medical Standards and Certification Procedures and Duration of Medical Certificates

Adopted: March 12, 1996 **Effective: September 16, 1996**

(Published in 61 FR 11238, March 19, 1996)

SUMMARY: This rule revises airman medical standards and medical certification procedures. The amendments implement a number of recommendations resulting from a comprehensive review of the medical standards announced in previous notices. This revision of the standards for airman medical certification and associated administrative procedures is necessary for aviation safety and reflects current medical knowledge, practice, and terminology. Also, this rule revises procedures for the special issuance of medical certificates (''waivers'') for those airmen who are otherwise not entitled to a medical certificate.

This rule also changes the duration of third-class airman medical certificates, based on the age of the airman, for operations requiring a private, recreational, or student pilot certificate.

Also, in this document, the FAA is announcing disposition of a number of petitions for rulemaking related to medical standards and duration of medical certificates.

FOR FURTHER INFORMATION CONTACT: Dennis McEachen, Manager, Aeromedical Standards and Substance Abuse Branch, 800 Independence Avenue, SW., Washington, DC 20591; telephone (202) 493–4075.

SUPPLEMENTARY INFORMATION:

Background

Current Requirements—Airman Medical Certification

Section 61.3(c) of Title 14 of the Code of Federal Regulations (14 CFR part 61) provides, with some exceptions, that no person may serve as pilot in command or in any other capacity as a required pilot flight crewmember unless that person has in his or her personal possession an appropriate current airman medical certificate issued under 14 CFR part 67. Part 67 provides for the issuance of three classes of medical certificates. A first-class medical certificate is required to exercise the privileges of an airline transport pilot certificate. Second- and third-class medical certificates are needed to exercise the privileges of commercial and private pilot certificates, respectively.

A person who is found to meet the appropriate medical standards, based on a medical examination and an evaluation of the applicant's history and condition, is entitled to a medical certificate without restrictions or limitations other than the prescribed limitation as to its duration. These medical standards are currently set forth in §§ 67.13, 67.15, and 67.17.

Special Issuance of Airman Medical Certificates

An applicant for a medical certificate who is unable to meet the standards in §§ 67.13, 67.15, or 67.17, and be entitled to a medical certificate, may nevertheless, be issued a medical certificate on a discretionary basis. Procedures for granting special issuances or exemptions have always been available,

and, thus, failure to meet the standards has never been absolutely disqualifying. Historically, approximately 99 percent of all applicants ultimately receive a medical certificate.

Under § 67.19, Special issue of medical certificates, at the discretion of the Federal Air Surgeon, acting on behalf of the Administrator under § 67.25, a special flight test, practical test, or medical evaluation may be conducted to determine that, notwithstanding the person's inability to meet the applicable medical standard, airman duties can be performed, with appropriate limitations or conditions, without endangering public safety. If this determination can be made, a medical certificate may be issued with appropriate safety limitations.

Duration of Airman Medical Certificates

Section 61.23 identifies the duration of validity and privileges of each class of medical certificate. Currently, a first-class medical certificate is valid for 6 months for operations requiring an airline transport pilot certificate, 12 months for operations requiring a commercial pilot certificate or an air traffic control tower operator certificate (for non-FAA controllers), and 24 months for operations requiring only a private, recreational, or student pilot certificate. A second-class medical certificate is valid for 12 months for operations requiring a commercial pilot certificate or an air traffic control tower operator certificate (for non-FAA controllers) and for 24 months for operations requiring only a private, recreational, or student pilot certificate. A third-class medical certificate currently is valid for 24 months for operations requiring a private, recreational, or student pilot certificate.

History

On October 21, 1994, the FAA published a notice of proposed rulemaking (NPRM) (Notice No. 94–31, 59 FR 53226) proposing to amend parts 61 and 67. The proposed revisions to part 67 were based on an agency review of part 67 which was announced in the preamble to Amendment 67–11 (47 FR 16298; April 15, 1982) and on recommendations from a report prepared for the FAA by the American Medical Association (AMA). In the preamble to Amendment 67–11, the FAA announced that it intended to conduct an overall review of the medical standards in part 67. A complete review of the regulations was needed to bring the standards and procedures for airman medical certification up to date with advances in medical knowledge, practice, and terminology. Amendment 67–11 was considered interim clarification until a comprehensive review of the medical standards contained in part 67 could be concluded.

The FAA began the review of the medical standards for airmen and of its certification practices and procedures by requesting public comment (47 FR 30795; July 15, 1982). In addition, the FAA initiated a contract with the AMA to provide professional and technical information. The AMA presented its report, ''Review of Part 67 of the Federal Air Regulations and the Medical Certification of Civilian Airmen'' (AMA Report), on March 26, 1986. The public was again invited to comment on part 67 in ''Announcement of the Availability of a Report'' (51 FR 19040; May 23, 1986). The AMA Report detailed the results of a comprehensive review of the standards for airman medical certification and of their application. The AMA Report considered pertinent advances in the field of medicine since 1959, recommended changes in the FAA medical standards, and explained the rationale for such changes. The FAA considered public comments received on the AMA Report in developing Notice No. 94–31.

In a separate but related issue, on May 11, 1979, the Aircraft Owners and Pilots Association (AOPA) petitioned to amend § 61.23 to require medical examinations for private pilots at 36-month intervals rather than at 24-month intervals. In response to the 1979 AOPA petition to amend § 61.23, the FAA issued on October 29, 1982, NPRM No. 82–15 (47 FR 54414, December 2, 1982) proposing to amend part 61 to revise the duration of validity of third-class privileges of airman medical certificates for operations requiring a private or student pilot certificate. As proposed by Notice No. 82–15, the requirement for a third-class medical examination would have been changed to every 5 years for the youngest pilots then increasing in frequency to the existing 2-year interval for older pilots.

On September 27, 1985, prior to the issuance of the AMA Report on its review of the airman medical standards and certification procedures in part 67, the notice proposing to amend part 61 to revise the duration of third-class airman medical certificates was withdrawn (50 FR 39619). The proposal was withdrawn, in part, because of issues raised by the medical community. Given the then pending issuance of the AMA Report and the possibility that the report would provide better data on which to base an evaluation of the safety concerns raised by the medical community, the FAA decided that any future consideration of examination frequency would be within the context of the outcome of the comprehensive review of part 67.

Petitions for Rulemaking

The FAA has received a number of other petitions for rulemaking that relate to airman medical certification and duration. These petitions are disposed of in this rulemaking. For each of these petitions a public docket was established, a notice of the petition was published in the *Federal Register*, and comments, if any, received on the petition were placed in the docket for public inspection.

On July 30, 1981, the Civil Pilots for Regulatory Reform petitioned the FAA to revise the rules so that pilots who have incurred a myocardial infarction will not be automatically disqualified for life for airman medical certification. (Docket No. 22054) This petition was discussed in the preamble to the NPRM (59 FR 53243). Also, see the discussion in this preamble under ''Cardiovascular §§ 67.111, 67.211, and 67.311'' and the corresponding rule language. Comments received on the petition totaled 311; all of which generally supported the petition. After careful consideration of all the comments, both from this petition and the current rulemaking action (Docket No. 27940), the FAA has determined that a diagnosis or medical history of myocardial infarction will continue to be disqualifying under part 67.

On February 26, 1986, AOPA again petitioned the FAA to revise the duration of a third-class airman medical certificate to 36 calendar months for noncommercial operations requiring a private, recreational, or student pilot certificate. (Docket No. 24932) See preamble discussion under ''Discussion of Comments and Amendments to Part 61'' (§ 61.23) and the corresponding rule language. Comments received on this petition totaled two; both supported the petition. After careful consideration of all comments, both from this petition and the current rulemaking action (Docket No. 27940), the FAA has decided to deny this AOPA petition and adopt the proposal (Docket No. 27940) with the modifications discussed under ''Discussion of Comments and Amendments to Part 61.''

On January 20, 1989, a petition was submitted to the FAA by Thomas J. Rush to provide a longer timeframe (60 or 90 days) for airmen to schedule medical examinations when they renew their special issuances of medical certificates. (Docket No. 25787) See the discussion in the preamble under ''Special Issuance § 67.401;'' ''Discussion of Comments and Amendments to Part 61;'' and the corresponding rule language. The *Federal Register* notice of this petition received no comment. After careful consideration of the issues of this petition and of comments to the current rulemaking action (Docket No. 27940), the FAA has determined that the rule as it relates to this issue should remain unchanged.

On February 12, 1990, AOPA petitioned the FAA to revise certain eye and cardiovascular standards to facilitate medical certificate issuance and better relate those standards to current medical knowledge and technology. Changes sought included the following: (1) Change the color vision standard for first-class medical certificates to the standard used for second-class medical certificates; and delete the color vision standard for third-class medical certificates; (2) Delete the uncorrected visual acuity standards; (3) Change the pathology of the eye standard for second-class medical certificates to the standard used for first-class medical certificates; and (4) For second- and third-class medical certificates, relate cardiovascular conditions to their impact on the applicant's ability to operate safely. (Docket No. 26156) See the discussion in the preamble under the major heading ''Vision §§ 67.103, 67.203, and 67.303'' (''Color Vision §§ 67.103(c), 67.203(c), and 67.303(c)''; ''Distant Visual Acuity''; ''Near Visual Acuity Standard''; and ''Intermediate Visual Acuity Standard''); and ''Cardiovascular §§ 67.111, 67.211, and 67.311''. Also see the corresponding rule language for these sections. Comments received on the petition totaled 80; 79 generally support the petition and 1 from the Air Line Pilots Association (now known as the Air Line Pilots Association International) (ALPA) opposed the petition. ALPA opposed the petition because they considered it premature in light of FAA's active rulemaking project to revise all of part 67. After careful consideration of all comments, both from this petition and the current rulemaking action (Docket No. 27940), the FAA has decided to adopt the vision and cardiovascular proposals of the current rulemaking action (Docket No. 27940) with the modifications discussed under ''Discussion of Comments and Final Rule for Part 67.''

On June 25, 1990, AOPA petitioned the FAA to amend frequently waived medical standards as follows: (1) Add a provision for continued limited pilot privileges pending FAA action on an application for renewal of a medical certificate; (2) Permit applicants for all classes of medical certificates to meet revised hearing standards in either or both ears with or without a corrective device; (3) Change the 2-year period of abstinence from alcohol to a period ''reasonable to ensure abstinence''; and (4) Permit issuance of second- and third-class medical certificates to diabetics using hypoglycemic drugs other than insulin (with Federal Air Surgeon concurrence). (Docket No. 26281) See the discussion in the preamble under ''Discussion of Comments and Amendments to Part 61'' (§ 61.23); ''Hearing §§ 67.105(a), 67.205(a), and 67.305(a)''; under the major heading ''Mental Standards §§ 67.107, 67.207, and 67.307'' (''Substance Dependence and Definitions'' and ''Substance Abuse''); and ''Diabetes §§ 67.113(a), 67.213(a), and 67.313(a)''. Also see the corresponding rule language for these sections. Comments received on the petition totaled 29; 28 generally supported the petition, and one from ALPA opposed the petition. ALPA opposed

the AOPA petition for the same reason it opposed the February 1990 AOPA petition; ALPA considered it premature in light of FAA's active rulemaking project to revise all of part 67. After careful consideration of all comments, both from this petition and the current rulemaking action (Docket No. 27940), the FAA has decided to adopt the duration, hearing, mental, and general medical proposals with the modifications discussed under ''Discussion of Comments and Amendments to Part 61'' and ''Discussion of Comments and Final Rule for Part 67.''

On August 27, 1990, a petition was submitted to the FAA by Frank Goeddeke, Jr., to allow individuals with alcoholism problems to obtain a medical certificate after abstaining from alcohol for 90 days, rather than the 2-year time period stipulated in the rules. (Docket No. 26330) See the discussion in the preamble under the major heading ''Mental Standards §§ 67.107, 67.207, and 67.307'' (''Substance Dependence and Definitions'' and ''Substance Abuse''). Also see the corresponding rule language for these sections. Comments received on the petition totaled three; all three supported the petition. After careful consideration of all comments, both from this petition and the current rulemaking action (Docket No. 27940), the FAA has decided to retain the 2-year abstinence requirement related to alcoholism.

In February 1991, the American Diabetes Association petitioned the FAA to amend the special issuance provisions of part 67 or, alternatively, amend the FAA special issuance policy to permit grants of special issuance of medical certificates to persons with insulin-treated diabetes mellitus (ITDM) and permit grants of special issuance of medical certificates on a case-by-case basis. The ADA also requested the creation of an FAA-appointed medical task force to develop a medical protocol to permit meaningful case-by-case review. (Docket No. 26493) The FAA referred to this petition in a request for comments on a proposed policy change concerning individuals with diabetes mellitus who require insulin that was published in the *Federal Register* on December 29, 1994. (See 59 FR 67246) See also the discussion in this preamble under ''Diabetes §§ 67.113(a), 67.213(a), and 67.313(a)'' and the corresponding rule language. Comments received on the petition totaled 160; there was general support for the rulemaking part of the petition. Most commenters, however, strongly support special issuance of medical certificates for persons with ITDM. After careful consideration of all comments, both from this petition and the current rulemaking action (Docket No. 27940), the FAA is denying that part of the ADA petition that requested rulemaking; i.e., an amendment to § 67.19. The FAA will respond to the ADA request for a policy change and to the comments received to both dockets when it publishes in a separate notice its disposition of the December 29, 1994, notice on that subject (Docket No. 26493).

On September 24, 1993, AOPA once again petitioned the FAA to revise the duration of a third-class airman medical certificate to 48 calendar months for a specific trial period for noncommercial operations requiring a private or student pilot certificate. (Docket No. 27473) See the preamble discussion under ''Discussion of Comments and Amendments to Part 61'' (§ 61.23) and the corresponding rule language. Comments received on the petition totaled 140; 137 generally supported the petition and 3 opposed it. After careful consideration of all comments, both from this petition and the current rulemaking action (Docket No. 27940), the FAA has decided to deny this AOPA petition and adopt the current rulemaking action's duration proposal (Docket No. 27940) with the modifications discussed under ''Discussion of Comments and Amendments to Part 61.''

The FAA considered each of these petitions for rulemaking and the public comments on the petitions in preparing the NPRM and this final rule. The FAA believes that the actions requested in the petitions are addressed and resolved in this rulemaking action. Therefore, action in each of the referenced petitions is considered completed by publication of this final rule.

The FAA is also addressing two other petitions for rulemaking relating to part 67. On August 14, 1991, a petition was submitted to the FAA by Charles Webber and on June 20, 1992, a petition was submitted to the FAA by Robert H. Monson. Both of these petitioners request that the FAA eliminate § 67.3 in its entirety. The petitioners state that this rule allows the FAA to obtain a copy of an applicant's automobile driving record before an airman medical certificate can be issued and that this violates individual privacy rights (under the Privacy Act, 5 United States Code (U.S.C.) 552a). (Docket No. 26782 and Docket No. 26913) Section 67.3 was added to part 67 in 1990 after the National Driver Register (NDR) Act of 1982 was amended to specifically authorize the FAA to receive information from the NDR regarding motor vehicle actions that pertain to any individual who has applied for an airman medical certificate. In the NPRM and in this final rule § 67.3 has been recodified as § 67.7. The substance of this section was not discussed in the NPRM for this rulemaking because the background, issues, and public comments had been thoroughly covered in the final rule for § 67.3 (August 1, 1990; 55 FR 31300). Since § 67.3 went into effect, the FAA has found access to the NDR useful in making medical certification determinations. Comments received to the Webber petition totaled 24; all generally supported the petition. The Monson petition received no comment. After careful consideration of both petitions and all the comments, both from the petitions and the current rulemaking action (Docket No. 27940), the FAA has determined it will take no further action on the referenced petitions after publication of this final rule.

In accordance with the above discussion and after consideration of comments received on the NPRM, the FAA is revising part 67 and §§ 61.23 and 61.39 of part 61.

Summary of Amendments to Part 67

The following is a summary of the substantive revisions made by this rulemaking. Because this rulemaking completely recodifies part 67, this summary states both the current and new section/paragraph numbers.

1. Distant visual acuity requirements for first- and second-class medical certification are changed to delete the uncorrected acuity standards. However, each eye must be corrected to 20/20 or better, as in the current standard. [Current §§ 67.13(b) and 67.15(b); Final §§ 67.103(a) and 67.203(a)]

2. For third-class medical certification, the current 20/50, uncorrected, or 20/30, corrected, distant visual acuity standard is changed to 20/40 or better, in each eye, with or without correction. [Current § 67.17(b); Final § 67.303(a)]

3. For first- and second-class medical certification, minimum near visual acuity requirements are specified in terms of Snellen equivalent (20/40), corrected or uncorrected, each eye, at 16 inches. This replaces the current standard of v=1.00 at 18 inches for first-class only. An intermediate visual acuity standard (near vision at 32 inches) of 20/40 or better at 32 inches Snellen equivalent, corrected or uncorrected, is added to the first- and second-class visual requirements for persons over age 50. [Current §§ 67.13(b) and 67.15(b); Final §§ 67.103(b), 67.203(b), and 67.303(b)]

4. A near visual acuity standard of 20/40 or better, Snellen equivalent (20/40), corrected or uncorrected, each eye, at 16 inches is added to the third-class visual requirements. [Current (None); Final § 67.303(b)]

5. Color vision requirements are amended to read: ''ability to perceive those colors necessary for safe performance of airman duties,'' and are the same for all classes. Current standards require ''normal color vision'' for first-class and the ability to distinguish aviation signal colors for second- and third-class applicants. [Current §§ 67.13(b), 67.15(b), and 67.17(b); Final §§ 67.103(c), 67.203(c), and 67.303(c)]

6. The current first-class standard pertaining to pathological conditions of the eye or adnexa that interfere or that may reasonably be expected to interfere with proper function of an eye is substituted in both the second- and third-class standards for the current standards which specify, respectively, ''no pathology of the eye'' and ''no serious pathology of the eye.'' [Current §§ 67.15(b) and 67.17(b); Final §§ 67.203(e) and 67.303(d)]

7. The ''whispered voice test'' for hearing is replaced for all classes by a conversational voice test using both ears at 6 feet; an audiometric word (speech) discrimination test to a score of at least 70 percent obtained in one ear or in a sound field environment; or pure tone audiometry according to a table of acceptable thresholds (American National Standards Institute (ANSI), 1969). [Current §§ 67.13(c), 67.15(c), and 67.17(c); Final §§ 67.105(a), 67.205(a), and 67.305(a)]

8. The standards pertaining to the ear, nose, mouth, pharynx, and larynx are revised to more general terms and related to flying and speech communication. Specific references to the mastoid and eardrum are deleted. The current standard, ''No disturbance in equilibrium,'' is changed to, ''No ear disease or condition manifested by, or that may reasonably be expected to be manifested by, vertigo or a disturbance of equilibrium.'' The amended standards are the same for all classes. [Current §§ 67.13(c), 67.15(c), and 67.17(c); Final §§ 67.105(b), 67.205(b), and 67.305(b)]

9. ''Psychosis,'' as used in the final rule, refers to a mental disorder in which the individual has delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition, or may reasonably be expected to manifest such symptoms. [Current §§ 67.13(d), 67.15(d), and 67.17(d); Final §§ 67.107(a), 67.207(a), and 67.307(a)]

10. Substance dependence and substance abuse are defined and specified as disqualifying medical conditions. Substance dependence is disqualifying unless there is clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including sustained total abstinence from the substance for not less than the preceding 2 years. Substance abuse is disqualifying if use of a substance was physically hazardous and if there has been at any other time an instance of the use of a substance also in a situation in which that use was physically hazardous; or if a person has received a verified positive drug test result under an anti-drug program of the Department of Transportation or one of its administrations within the preceding 2 years. Alcohol dependence and alcohol abuse are included in the terms ''substance dependence'' and ''substance abuse'', respectively. [Current §§ 67.13(d), 67.15(d), and 67.17(d); Final §§ 67.107(a) and (b), 67.207(a) and (b), and 67.307(a) and (b)]

11. ''Bipolar disorder'' is added as a specifically disqualifying condition. This addresses an issue created by a change in nomenclature contained in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III), and continued in the DSM IV. [Current (None); Final §§ 67.107(a), 67.207(a), and 67.307(a)]

12. The general mental standard is amended to add the word ''other'' before ''mental.'' The final revised standard reads, ''No other personality disorder, neurosis, or other mental condition . . . .'' [Current §§ 67.13(d), 67.15(d), and 67.17(d); Final §§ 67.107(c), 67.207(c), and 67.307(c)]

13. ''A transient loss of control of nervous system function(s) without satisfactory medical explanation of the cause,'' is added as a specifically disqualifying neurologic condition. [Current (None); Final §§ 67.109(a), 67.209(a), and 67.309(a)]

14. The word ''seizure,'' is substituted for ''convulsive.'' [Current §§ 67.13(d), 67.15(d), and 67.17(d); Final §§ 67.109(b), 67.209(b), and 67.309(b)]

15. ''Cardiac valve replacement,'' ''permanent cardiac pacemaker implantation,'' and ''heart replacement'' are added as specifically disqualifying cardiovascular conditions for all classes of certification. [Current §§ 67.13(e), 67.15(e), and 67.17(e); Final §§ 67.111(a); 67.211 (d), (e), and (f); and 67.311 (d), (e), and (f)]

16. The time period for which an electrocardiogram may be used to satisfy the requirements of the first-class medical certificate is revised to 60 days from the current 90 days. [Current § 67.13(e); Final §§ 67.111(c)]

17. The current table of age-related maximum blood pressure readings for applicants for first-class medical certificates and the reference to ''circulatory efficiency'' are deleted. Blood pressure will continue to be assessed for all three classes but will be evaluated under the appropriate general medical standards. [Current § 67.13(e); Final §§ 67.113(b), 67.213(b), and 67.313(b)]

18. Current § 67.19, Special issue of medical certificates, is rewritten [Final § 67.401(a)] to provide for, at the discretion of the Federal Air Surgeon, an ''Authorization for a Special Issuance of Medical Certificate'' (Authorization), valid for a specified period of time. An individual who does not meet the published standards of part 67 may be issued a medical certificate of the appropriate class if he or she possesses a valid Authorization. The duration of any medical certificate issued in accordance with proposed § 67.401 is for the period specified at the time of its issuance or until withdrawal of an Authorization upon which the certificate is based. A new Authorization is required after expiration, and the applicant must again apply for a special issuance of a medical certificate.

19. Final § 67.401(b) provides for a Statement of Demonstrated Ability (SODA) instead of an Authorization. A SODA will be issued with no expiration date to applicants whose disqualifying conditions are static or nonprogressive and who have been found capable of performing airman duties without endangering public safety. A SODA authorizes an aviation medical examiner to issue a medical certificate if the applicant is otherwise eligible.

20. Final § 67.401(e) retains the language of current § 67.19(c) regarding consideration of the freedom of a private pilot to accept reasonable risks to his or her own person or property that are not acceptable in the exercise of commercial or airline transport pilot privileges, and consideration at the same time of the need to protect the safety of persons and property in other aircraft and on the ground.

21. Final § 67.401(f) adds language that explicitly provides that the Federal Air Surgeon may withdraw the Authorization or SODA. An Authorization or SODA may be withdrawn at any time for (1) adverse change in medical condition, (2) failure to comply with its provisions, (3) potential endangerment of public safety, (4) failure to provide medical information, or (5) the making or causing to be made of a statement that is covered by § 67.403.

22. Final § 67.401(i) permits a person to request that the Federal Air Surgeon review a decision to withdraw an Authorization or SODA. The request for a review must be made within 60 days of the service of the letter that withdrew the Authorization or SODA. The review procedures will be on an expedited basis and will provide the affected holder of an Authorization or SODA a full opportunity to respond to a withdrawal by submitting supporting appropriate evidence.

23. Final § 67.403 differs from current § 67.20 by providing for denial of an airman medical certificate if the application for an airman medical certificate is falsified. Though this consequence is implied, the current regulation specifically provides only for revocation or suspension of certificates. Additionally, § 67.403 provides for denial or withdrawal of any Authorization or SODA if the information provided to obtain it is false, whether the statement was knowingly false or unknowingly incorrect. Finally, § 67.403(c) makes an unknowingly incorrect statement that the FAA relied upon in making its decisions regarding

an application for an airman medical certificate or a request for an Authorization or SODA, a basis for denial, revocation, or suspension of an airman medical certificate and the denial or withdrawal of an Authorization or SODA.

24. A new § 67.415 provides that the holder of any medical certificate that is suspended or revoked shall, upon the Administrator's request, return it to the Administrator. The FAA practice always has been to request return of the certificate in such circumstances to avoid any misunderstanding as to the validity of the certificate.

25. Where appropriate, changes are made to eliminate gender-specific pronouns, to replace ''applicant'' with ''person,'' to use current position titles and addresses, to correct spelling and improve syntax, and to adjust section and paragraph references.

General Discussion of Public Comments

In response to the NPRM, the FAA received over 5,200 written comments from the public. In addition, in January of 1995, the FAA held three public meetings on the proposal, at which approximately 50 individuals and organizations participated. One was held in Washington, D.C., one in Orlando, Florida, and one in Seattle, Washington. Information from both the written comments to the docket and the presentations at these public meetings was considered in the final rule decisions along with the petitions for rulemaking and the comments received to those dockets discussed above.

Commenters include approximately 30 trade associations, over 20 FAA aviation medical examiners (AME's), and over 5,100 members of the general public. Air transport pilots and other commercial pilots, private and recreational pilots, flight schools, and flight instructors were among the public commenters.

A substantial number of commenters oppose the proposed changes on the basis that these changes would be a financial burden, that there is a lack of accident data to support stricter standards, and that the stricter standards would not produce discernible safety benefits. There was little or no opposition, however, to proposed changes that relaxed standards or reduced the regulatory burden.

The FAA carefully considered each comment and all presentations made at the public meetings in determining this final rule. Comments that address specific proposed requirements relevant to the proposed rule are summarized and responded to in the following sections of this preamble. To the extent possible, all comments relevant to the adopted standards and regulatory changes are addressed; issues not relevant to this rulemaking raised in the written comments or at the public meetings are not addressed in this document.

The FAA has determined that several of the proposed stricter standards are not required at this time. The withdrawal of these proposed stricter standards are fully discussed in the relevant sections of this document.

Overall Justification and Authority for This Rulemaking

AOPA, which represents the interests of 330,000 pilots and aircraft owners, states in its comment that there is not sufficient justification to warrant this rulemaking since more than 98 percent of all general aviation accidents do not involve medical factors. AOPA also asserts that the FAA's statutory authority for regulating medical standards does not justify the medical certification program currently in place, especially with respect to persons who exercise only private or recreational flying privileges. AOPA states that it is unable to identify a grant of authority to the Administrator to deny a medical certificate to a pilot based, not on the pilot's present physical ability but on the finding that a condition may reasonably be expected within 2 years after the finding to make the pilot unable to perform the required duties. AOPA believes that the FAA should reconsider whether the proposal goes beyond the intent of the Federal Aviation Act of 1958 and beyond what is necessary to safety in air commerce.

In a related comment, the Independent Pilots Association (IPA) states that ''nowhere is the FAA or the Federal Air Surgeon charged with the duty to practice preventive medicine.''

FAA Response: The FAA has not gone beyond the intent of its authority in this rulemaking action. As stated previously in this notice, the purpose of this rulemaking is to update the medical standards to reflect current medical knowledge, practice, and terminology. The FAA is authorized under 49 U.S.C. 44703 to find that an applicant for an airman certificate is physically able to perform duties pertaining to the position for which the certificate is sought. The FAA is to issue such a certificate ''containing such terms, conditions, and limitations as to duration thereof, periodic or special examinations, tests of physical fitness, and other matters'' necessary to assure aviation safety.

It is reasonable that airmen, sharing the same air space and flying over the same populated areas, whether engaged in air transportation or in private operations, must meet certain standards in skills and

medical fitness to assure aviation safety. That some distinction in the degree of standards is permissible is reflected in the distinction between types of pilot certificates and classes of medical certificates as required by law. While the FAA is not charged with the duty to practice preventive medicine, determining the medical fitness of airmen requires making an assessment of the risks involved in certain medical conditions and denying medical certification in instances in which the person is, or may be, unable to safely perform aviation activities.

On reconsideration of the proposal and after careful consideration of all the comments and presentations received, the FAA is withdrawing certain proposed requirements. Among the withdrawals are (1) the proposal to shorten the duration of third-class medical certificates for pilots 70 and older, (2) the requirement for a test to determine total blood cholesterol, and (3) electrocardiogram requirements for second-class medical certificates. A more complete discussion of the withdrawal of the requirements occurs in the following sections of the preamble.

One of the FAA's primary concerns is the need to ensure that its regulations maintain the proper balance between cost and benefits. The FAA will only issue a final rule when there is clear evidence that it will enhance safety, and that it will do so at a reasonable cost. This is a longstanding FAA commitment, and a requirement of DOT policies and procedures. In this context, after review of the comments, the FAA is not persuaded that there is yet adequate evidence to show that those costs of the proposals are justified by the safety benefits that can reasonably be expected.

However, the FAA will continue to monitor accident and health data as part of our responsibility to help ensure that adequate safety is maintained. Consistent with the principles of the Clinton administration's National Performance Review, the FAA will, in the coming months, explore alternative nonregulatory means to reduce medically-related accidents. These alternative administrative actions will not impose the same costs on airmen as the proposals contained in the NPRM, but will assist pilots and aviation medical examiners in identifying and reducing potential medical risks.

National Transportation Safety Board (NTSB) and Judicial Review

Several associations and individuals comment that this rulemaking appears to be an effort by the FAA to change decisions by the NTSB and the courts. Several individuals at the hearings held in conjunction with this rulemaking also expressed this opinion.

FAA Response: The FAA agrees that in some cases these comments are accurate. The FAA promulgates rules and policies when the FAA determines that a substantial public safety interest requires such action. In some circumstances, the NTSB or the courts have determined that the rule language adopted by the FAA does not achieve the FAA's intent. The FAA views the circumstances in which review authorities have disagreed with the FAA's interpretation of its rules as a reflection of regulatory defects and not a reflection of policy defects. This rule corrects the regulatory defects by clarifying or more accurately stating in the regulatory language those policies that the FAA believes are necessary to protect substantial public safety interests.

Discussion of Comments and Amendments to Part 61

Proposed § 61.23 lengthens the current 2-year third-class medical certification period to a 3-tier system: a 3-year period for pilots under age 40, a 2-year period for those age 40 to 69, and annual certification for pilots age 70 and over.

Comments: Most individual commenters expressed support for the increased duration (from 2 years to 3 years) for third-class medical certificates for pilots under age 40. Several AME's comment that it is appropriate to differentiate for age, although opinions of AME's and other commenters vary as to the age at which the frequency of examinations should change. Commenters suggest duration periods for third-class medical certificates ranging from 1 to 5 years.

Several associations, several AME's, and a majority of the individuals who commented on this issue strongly oppose the proposal to increase the frequency of medical examinations for pilots age 70 and over for reasons including the following: the proposal may be illegal under federal age discrimination laws; more frequent examinations will not predict sudden incapacitation; the benefits have not been demonstrated; accident rates are lower for older pilots; and the statistical analysis the FAA used to confirm that incidence of accidents increases with age is supported by an insufficient sample size. The Experimental Aircraft Association (EAA), AOPA, and the Colorado Pilots Association believe all airmen should have a 3-year standard regardless of age because, until medical technology reaches a point where the onset of a heart attack can be accurately predicted, there is no justification for more frequent or different examinations for pilots age 70 or over.

Some commenters say that the requirement will be particularly burdensome to older pilots, many of whom are on a fixed income. One commenter suggests that the FAA pay for annual examinations if they will be required. Several commenters note that such examinations are generally not covered by insurance.

FAA Response: The FAA has decided to lengthen the current 2-year third-class medical certification period to a 2-tier system. For airmen under age 40, medical certificates must be renewed every 3 years. For airmen age 40 and over, the current 2-year duration will remain.

As stated in the NPRM, extending the length of time between examinations for third-class medical certificates of persons under age 40 should result in no significant increase in undetected pathology between required examinations. The FAA, after careful consideration of all comments and testimony received as well as the petitions and comments received to Docket Nos. 24932, 26281, and 27473, has determined that extending the duration between medical examinations can be done with no detriment to safety in the case of younger airmen who are much less likely to suffer medical incapacitation. As with all age groups, those individuals under age 40 manifesting conditions that represent a risk to safety will be denied certification or, if they apply for and receive a special issuance of a medical certificate, will be restricted in their flying activities or examined more thoroughly and frequently, or both.

The final rule will provide for maximum regulatory relief without a decrement to public safety.

The proposal to shorten the duration of third-class medical certificates of airmen over the age of 70 is being withdrawn because on reexamination insufficient data exist to support the revision at this time. Several aviation associations, AME's, and individuals commented that the data used in the proposal did not support the conclusion that decreased accidents would result if the duration of third-class medical certificates for airmen over the age of 70 was shortened. The FAA has determined that the possible reduction of a very few known general aviation accidents that are medically-related cannot be justified when compared with the cost of the proposal. This is in contrast to accidents of airline transport and commercial carriers where a single accident may have significant loss of life and property.

All third-class medical certificates or third-class privileges of a first- or second-class medical certificate issued prior to the effective date of this final rule will remain valid for 2 years from the date of issuance of the certificate unless the validity period has been otherwise limited by the FAA. The period of validity for all third-class airman medical certificates or third-class privileges of a first- or second-class medical certificate issued on or after the effective date of this final rule will be calculated according to the provisions of the final rule unless the validity period is otherwise limited by the FAA.

Section 61.53 provides that: ''No person may act as pilot in command, or in any other capacity as a required pilot flight crewmember while he [or she] has a known medical deficiency, or increase of a known medical deficiency, that would make him [or her] unable to meet the requirements for his [or her] current medical certificate.'' This amendment does not change § 61.53, and the FAA continues to require airmen to comply with that rule. In reducing the frequency of required periodic contacts with knowledgeable health professionals, self-monitoring and personal attention to health become a more important part of the individual airman's responsibility for flight safety.

Consistent with the changes above, the final rule amends § 61.39 to coincide with the duration change in § 61.23. Section 61.39 requires that applicants must possess at least a third-class medical certificate or the third-class privileges of a first- or second-class medical certificate valid under § 61.23 in order to be eligible for a flight test for a certificate, or an aircraft or instrument rating.

Discussion of Comments and Final Rule for Part 67

The following discussion generally addresses comments received and the FAA's response to those comments on the specific standards or requirements in the rule. As noted above, over 5,200 comments were received concerning this rulemaking. The comments addressed by the FAA are broadly representative of these many thousands of comments. Other matters and issues raised by the commenters, such as additional tests and examinations that are performed under the special issuance procedures, are not addressed in this document. The FAA is responding only to comments that are within the scope of this rulemaking.

Lists of Medical Standards

General

''Include, but are not limited to.'' The proposal uses the word ''includes'' rather than the word ''are'' in each section of the medical standards because the proposed medical standards are not, and never have been, meant to be exhaustive in naming all medical conditions that are disqualifying.

Comments: AOPA, EAA, National Air Transportation Association (NATA), and most individual commenters say this provision gives FAA absolute discretion without proper promulgation of regulations; the language is too open-ended and provides no standard at all. AOPA states that because the disqualifying conditions are not enumerated, applicants cannot know if they have a deficiency for which the FAA would disqualify them. One AME says that the proposal gives the FAA too much leeway, and should read ''are limited to.'' A majority of the individual commenters strongly oppose use of the term ''include, but are not limited to,'' saying that it would allow FAA too much unchecked authority over an applicant.

FAA Response: The final rule will not contain the proposed language ''include, but are not limited to.'' Medical conditions identified during an evaluation that are not specifically listed as disqualifying but do not meet the general medical standard regarding safe performance of duties and exercise of privileges, would continue to be disqualifying under general medical standards. The intent of the proposal was to alert individuals of this long-standing FAA practice and not to expand the scope of the regulations.

Vision (§§ 67.103, 67.203, 67.303)

Distant Visual Acuity. The proposal deletes the uncorrected vision standard for first- and second-class medical certificates and requires a distant visual acuity of 20/20 or better, in each eye, with or without correction. For third-class medical certificates, a distant visual acuity of 20/40 or better with or without correction, is required for each eye.

Comments: Comments on the proposal for distant visual acuity were in favor of the changes; one AME notes that the proposal is less stringent than the present standards.

FAA Response: The final rule is the same as proposed in the NPRM. As stated in the NPRM, the FAA practice for many years has been to grant any class medical certificate requested, regardless of uncorrected distant acuity, if the required minimum vision is present or achieved through conventional corrective lenses, there is no evidence of significant eye pathology, and the person is otherwise eligible. Thousands of airmen have demonstrated their ability to safely perform their jobs while using corrective lenses for distant visual acuity that is poorer than 20/100 in each eye. The FAA, after careful consideration of the comments and presentations received as well as the petition and comments received to Docket No. 26156, has determined that the requirements for distant visual acuity may be relaxed. The revision will streamline the process of medical certification by not requiring special issuance for persons who cannot meet an uncorrected distant acuity standard.

Near visual acuity standard. The proposed rule replaces the outdated standards for near visual acuity by requiring for all three classes a near visual acuity of 20/40 or better, Snellen equivalent, at 16 inches in each eye separately, with or without corrective lenses.

Comments: United States Pilots Association (USPA) states that the FAA presented no evidence to justify the addition of a near-vision standard. Joint Aviation Authorities (JAA) also notes the lack of accident-supported data, but states that the European opinion is that the pilot should have enough visual capacity to read the aircraft instruments if his or her glasses or lenses are lost in flight. The EAA suggests changing 16 inches to ''ability to read an instrument panel,'' which would preserve the intent of the rule, but would not require any additional equipment or training of AME's.

Three AME's approve and one disapproves of the proposed near visual acuity standards. One AME doubts that a pilot with 20/40 vision can read small print (such as on instrument approach plates) in dim light, but notes that a nearsighted person can compensate by looking around one's spectacle lenses. Farsighted persons with 20/40 vision, however, may not be able to read small print at 16 inches. This commenter suggests (1) supplying AME's with specimen aeronautical charts and plates and requiring that the items be read in normal room light with or without correcting lenses, or (2) raising the near vision standard to at least 20/25.

FAA Response: The FAA agrees with the AMA Report recommendation that all three classes of medical certificates should have the same near visual acuity standards. The final rule is the same as proposed. It eliminates the antiquated terminology in the current standards for first-class medical certification, corrects the inconsistency between standards and practice for second-class medical certification, and establishes a standard for third-class medical certificates. After careful consideration of all comments and presentations received as well as the petition and comments received to Docket No. 26156, the FAA has determined that the near visual acuity standard proposed in the NPRM establishes an objective requirement that is necessary for safety and can be best accomplished by the final rule.

Intermediate visual acuity standard. The NPRM proposed to add a new intermediate visual acuity standard (near vision at 32 inches) for first- and second-class medical certificates for pilots age 50 or older of 20/40, Snellen equivalent, at 32 inches in each eye separately, with or without corrective lenses.

Comments: The AMA states that all pilot applicants older than 50 should have 20/40 visual acuity at 32 inches because they need this degree for proper sight and use of instruments, switches, and other controls.

Regarding intermediate visual acuity, AOPA says that 20/40 at 32 inches over age 50 is unjustified, and that the age criteria is arbitrary. One AME says there are no data or operational experience to suggest that an additional middle vision standard for older pilots is needed. According to one AME, the 32-inch intermediate vision standard is too strict for pilots over 50 and will add to the cost without adding any discernible benefit. According to this commenter, those who need trifocals already have them.

FAA Response: The final rule includes a requirement for intermediate visual acuity for first- and second-class medical certificates for pilots age 50 or older. This standard is consistent with the International Civil Aviation Organization (ICAO) standards. The AMA Report recommended this intermediate vision standard in light of the eye's diminished ability with age to accommodate intermediate viewing distances. Also, the NTSB has recommended that an intermediate vision standard be established. The FAA, after careful consideration of the comments received as well as the petition and comments received to Docket No. 26156, has determined to adopt the rule proposed in the NPRM; airline transport and commercial pilots need adequate intermediate vision to monitor aircraft instruments and other cockpit equipment. This standard is also necessary to safeguard the public safety.

Color Vision (§§ 67.103(c), 67.203(c), 67.303(c))

The proposed color vision standard for all classes is the ''ability to perceive those colors necessary for safe performance of airman duties.'' Current standards require ''normal color vision'' for first-class applicants and the ability to distinguish aviation signal colors for second- and third-class applicants.

Comments: The USPA, NATA, and National Agricultural Aviation Association (NAAA) support the proposed simplification of the color vision standard.

One AME states that the current system is adequate to identify the individual with a color vision problem and should be left intact. This commenter states that the proposed NPRM advances no new or improved method of determining color vision abilities.

AOPA and the AMA say that the regulations as proposed leave too much room for inconsistent interpretation; the rule should precisely state what colors are ''necessary for the safe performance of airman duties'' and what tests should be done. An individual suggests using visual flight rule (VFR) charts and runway and taxi light colors as discriminants for realistic and practical color vision tests. EAA says that the FAA should change the wording ''safe performance of airman duties'' to ''read and understand a sectional aeronautical chart.'' EAA believes this would ensure the intent of the rule, give the AME a simple inexpensive test, and better define what is necessary for safe performance of duties.

Aerospace Medical Association (ASMA) and Air Transport Association (ATA) oppose the proposed changes. ASMA suggests that the FAA discontinue the color blindness test; the standard should be based on an individual's ability to perform safely.

FAA Response: The final rule for color vision is the same as proposed. As stated in the NPRM, in current practice applicants for certification are tested by use of standard pseudoisochromatic plates or by other approved devices. A passing score defines the applicant as not color deficient. Failure indicates a color deficiency and requires that any medical certificate issued be limited, prohibiting flight at night or by color signal control. The limitation can be removed by successful completion of a practical signal light test or of a medical flight test, as appropriate for the class medical certificate sought and the level of aviation experience of the applicant. This final rule would allow, for all three classes of medical certificates, an individual who fails the test using pseudoisochromatic plates or other approved devices to still obtain a medical certificate without obtaining a waiver as long as the individual can demonstrate an ability to perceive those colors necessary for the safe performance of airman duties. The FAA will provide guidance to AME's to assist in these tests.

The FAA, after careful consideration of the comments and presentations received as well as the petition and comments received to Docket No. 26156, has determined that the color vision standard in the final rule should remain as proposed.

Hearing (§§ 67.105(a), 67.205(a), 67.305(a))

In the proposed rule, the ''whispered voice test'' for hearing is deleted for all classes and replaced with three alternatives: (1) A conversational voice test using both ears at 6 feet; (2) an audiometric word (speech) discrimination test to a score of at least 70 percent obtained in one ear or in a sound

field environment; or (3) pure tone audiometry according to a table of acceptable thresholds (ANSI, 1969).

Comments: Some AME's generally support the proposed hearing standards. ASMA states, however, that the rule language could be interpreted to require audiograms and that the FAA should state in the preamble that it intends for the basic screening test to be the spoken-voice test. ASMA also says that the rule should state that audiometric tests are only used as alternatives for further evaluation of individuals who show reduced hearing acuity.

Many commenters support the ''conversational voice'' recognition standard as operationally relevant. AOPA and USPA support the proposed standard that allows both ears to be used simultaneously to hear conversational voice spoken at 6 feet.

ATA says a pure tone audiogram followed by a speech discrimination test based upon an audiometric standard guideline would be a far more accurate and objective measurement of hearing than the highly subjective conversational and whispered voice tests.

ATA says that a 70 percent score on an audiometric word discrimination test is too low to support speech comprehension during critical phases of flight; the standard should be 95 percent. Another individual suggests that 85 percent would allow for accurate communication in more cockpit environments. ATA and one AME also believe that the rule is vague, should be more descriptive, and should cite a decibel reading for administering the test.

One AME says that possibly a screening cut-off level for pure-tone audiometry would be appropriate.

AOPA says that the same screening test should apply for those without ''normal hearing'' and users of hearing aids. According to AOPA, there appears to be no clinical reason for excluding the use of hearing aids within the medical standards.

Several commenters question whether an ''and'' or an ''or'' is appropriate between subparagraphs (a)(1) and (a)(2) of §§ 67.105, 67.205, and 67.305. Most think the rule should say ''or.''

A commenter notes that the standard for 2000 Hz in the chart in § 67.205(c) is 30 for the poorer ear, which is more stringent than the standard of 50 for first-class medical certificate. The commenter believes that this must be a typographical error.

FAA Response: The final rule is the same as proposed, except that the typographical error in the chart in § 67.205(c) is corrected to 50 and the lead-in for paragraph (a) in all three sections reads: ''The person shall demonstrate acceptable hearing by at least one of the following tests:'' and a period is placed at the end of each subparagraph. These editorial corrections to paragraph (a) are intended to eliminate any confusion or ambiguity. Passing any one of the tests, as required, is acceptable for certification. The FAA anticipates that the conversational voice test will be the most commonly used; however, passing any one of the tests will suffice even if the applicant has failed the other two. While there is some subjectivity to a conversational voice test, it is the simplest and least expensive form of testing. The FAA, after careful consideration of the comments and presentations received as well as the petition and comments received to Docket No. 26281, has determined that the hearing standards in the final rule should remain as proposed.

The FAA is following the AMA Report recommendations in requiring a 70 percent score in an audiometric word discrimination test. The FAA considers a 95 percent score too restrictive.

As with current policy, if a hearing aid is necessary to meet the standard, an Authorization or SODA is required. In most cases, however, a person using a hearing aid can be issued a medical certificate.

Equilibrium (§§ 67.105(c), 67.205(c), 67.305(c))

The proposal revises the current standard, ''No disturbance in equilibrium,'' to, ''No ear disease or condition manifested by, or that may reasonably be expected to be manifested by, vertigo or a disturbance of equilibrium.'' The proposed standards are the same for all classes.

Comments: One commenter states that the ear, nose, throat, and equilibrium revisions are appropriate and realistic for addressing safety.

AOPA and other commenters say that the language relating to vertigo or disturbance of equilibrium is too broad; instead the rule should qualify that an applicant shall have ''no disturbance of equilibrium that is severe enough to make piloting an aircraft unsafe.'' AOPA asserts that vertigo is a common and normal occurrence and disqualification should not be based on a symptom. According to AOPA an episode of in-flight vertigo is not necessarily attributable to an underlying medical condition that

is disqualifying. AOPA notes that the FAA intentionally induces vertigo at safety seminars using a ''vertigon'' chair.

FAA Response: The final rule is the same as proposed. The final rule is more precise than the current rule since it specifies that the vertigo or disturbance of equilibrium be a manifestation of a condition or disease of the ear. It appears commenters are confusing pilot vertigo or spatial disorientation that can occur in flight with vertigo that is a manifestation of a medical condition or disease. In-flight pilot vertigo or spatial disorientation is not related to this medical standard. The FAA has determined, after careful consideration of the comments and presentations received, that the equilibrium standards in the final rule should remain as proposed.

Mental Standards (§§ 67.107, 67.207, 67.307)

Definition of Psychosis. The proposed rule states that ''psychosis'' refers to ''a mental disorder in which the individual has manifested psychotic symptoms or to a mental disorder in which the individual may reasonably be expected to manifest psychotic symptoms.'' This language change was proposed to be consistent with the diagnostic terminology and classification of mental disorders, published in the DSM III and its successor DSM IV.

Comments: ATA suggests identifying the underlying disorders that FAA considers psychoses, e.g., schizophrenia, paranoid states, or depression. ATA suggests defining psychosis as ''an alteration in either thought content or process, or both, to such an extent that the individual suffers from hallucinations, delusions, or other manifestations.'' One AME states that ''psychotic reaction'' needs further definition in the rule. IPA suggests that the FAA refrain from referring to a specific edition of the DSM since DSM-IV is the current psychiatric diagnostic standard, not the 15-year old DSM-III referenced in the NPRM. JAA says its Manual of Civil Aviation Medicine gives much more detailed interpretation of its psychiatric and psychological requirements.

FAA Response: On reconsideration and after careful consideration of the comments received, the FAA has changed the final rule language regarding psychosis to be more specific. Paragraph (a)(2) of §§ 67.107, 67.207, and 67.307 reads as follows:

> ''(2) A psychosis. As used in this section, 'psychosis' refers to a mental disorder in which:
>
> ''(i) The individual has manifested delusions, hallucinations, grossly bizarre or disorganized behavior or other commonly accepted symptoms of this condition; or
>
> ''(ii) The individual may reasonably be expected to manifest delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition.''

At the time of the AMA Report and the FAA review of part 67, the most current DSM was DSM III. Since then, the DSM has been revised and the most current version is DSM IV. The FAA has determined that the revisions between DSM III and DSM IV do not necessitate any substantive changes between the proposed rule and the final rule.

Bipolar disorder. The proposed rule adds bipolar disorder (formerly ''manic depressive psychosis'') as a specifically disqualifying mental condition because the American Psychiatric Association's nomenclature in DSM III and DSM IV no longer includes bipolar disorder within the category of psychoses.

Comments: One AME and a few individuals support the proposal to make bipolar disorders disqualifying.

AOPA believes bipolar disorder should not be singled out as a disqualifying mental condition, and that applicants should be evaluated on a case-by-case basis. AOPA asserts that bipolar disorders vary in severity and symptoms from one individual to another; some never exhibit the manic symptoms which appear to be the primary concern of the FAA.

FAA Response: The FAA, after careful consideration of the comments and presentations received, has determined that the final rule be the same as proposed. However, since the proposed rule was issued, DSM IV was developed which refers to more than one bipolar disorder and to separate criteria that apply to the different types of bipolar disorders. Although the DSM IV contains a change in classification of this disorder, there is no change in the rule language from the proposed rule language because the disorder, whatever its classification, is considered disqualifying.

The FAA believes these conditions are of concern in the context of airman medical certification and flight safety, and that the agency must amend the mental standards since in accordance with the DSM III and its successor DSM IV, psychoses no longer include bipolar disorders. In consideration of potential risk to flight safety, individuals with this diagnosis are rarely granted certification. Those

few individuals who are determined to be eligible for certification through the special issuance provisions must be followed closely for relapse and recurrence of symptoms. By including the new terminology, the standards will clearly reflect the agency's concern about this disorder. Specifically listing bipolar disorders as disqualifying is not a substantive change in FAA policy or practice.

Substance Dependence and Definitions. The proposal updates the standards for alcoholism and drug dependence to make them consistent with DSM III (and subsequently DSM IV) nomenclature which eliminates the term ''alcoholism'' and substitutes the diagnoses of ''substance dependence'' and ''substance abuse.'' The proposed revision defines ''substance dependence,'' ''substance abuse,'' and ''substance.'' The proposed revision identifies disqualifying substances or groups of substances (e.g., alcohol, cocaine, opioids, hallucinogens, cannabis, etc.) and would make dependence on or abuse of them disqualifying. The proposal also makes substance dependence disqualifying unless there is clinical evidence of recovery, including sustained total abstinence for not less than the preceding 2 years in the case of alcohol dependence, and the preceding 5 years in the case of other substance dependence.

Comments: Two AME's generally support the proposed changes regarding substance dependence. AOPA, National Air Traffic Controllers Association (NATCA), EAA, and two other AME's suggest a minimum 2-year abstinence for all substances because they believe the extended period of decertification for substance dependency is without statistical justification. According to these commenters, the AMA data on which the 5-year restriction is based are dated; there are many new treatments and research that indicate a required 5-year abstinence is too strict; and the 5-year rule may reflect some public hysteria concerning drug use. In addition, according to these commenters, there are six times as many alcohol-related accidents as drug-related accidents, bringing into question why the FAA is proposing stricter standards on other substances when alcohol is a greater problem.

Two AME's say the FAA should not broaden the substances and should leave the regulation as is. Another AME says FAA needs to further define ''substance'' by identifying particular drugs.

EAA says that the FAA should limit the disqualification for muscle relaxants to users of ''muscle relaxants with habit-forming potential'' because many muscle relaxants have no habit-forming potential.

FAA Response: The FAA, after careful consideration of the comments and presentations received as well as the petitions and comments received to Docket Nos. 26281 and 26330, has decided to make the minimum period of abstinence from alcohol and other substances 2 years because longer term experience with recovery from dependence on drugs or alcohol now suggest that 2 years is adequate for both alcohol and drugs. In many cases, the FAA has granted special issuance to air transport and commercial pilots and has waived the 2-year abstinence period when it was satisfied that certain stringent criteria are met. The criteria can be summarized as follows: (1) A full commitment and partnership of the aviation employer and employee to ensure the employee's continued sobriety through monitoring; (2) full commitment and partnership of the recovering employee with a fellow employee to ensure continued sobriety through monitoring; and (3) frequent evaluations, testing, and attendance at professional aftercare treatment.

Also, the FAA has decided to delete ''muscle relaxants'' from the list of substances in §§ 67.107(a)(4)(i), 67.207(a)(4)(i), and 67.307(a)(4)(i) in part because the FAA agrees with the EAA comment, but also because muscle relaxants are not included as a substance in DSM III and its successor DSM IV.

To conform with DSM IV terminology, the FAA has changed the reference to ''volatile solvents and gases'' to ''inhalants,'' a term the FAA considers to be equivalent.

Otherwise the final rule is the same as proposed. The standards are consistent with the AMA Report and address the national concerns about substance dependence.

Substance abuse. As proposed, substance abuse is one of the following:

(1) Use of alcohol within the preceding 2 years in a situation in which that use is physically hazardous, if there has been at any other time an instance of the use of alcohol or another substance also in a situation in which that use was physically hazardous; or

(2) Use of a substance other than alcohol within the preceding 5 years in a situation in which that use is physically hazardous, if there has been at any other time an instance of the use of that substance, alcohol, or another substance also in a situation in which that use was physically hazardous;

(3) Use of a prohibited drug defined in appendix I of part 121 of this chapter within the preceding 5 years; or

(4) Misuse of a substance within the preceding 2 years if alcohol or within the preceding 5 years if another substance, that the Federal Air Surgeon based on case history and appropriate qualified medical judgment, finds—

(i) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held or

(ii) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

Comments: Two AME's and other commenters generally support the proposed changes to the substance abuse standard.

The JAA states that the proposed recommendations are similar to those in the JAA proposals except that a shorter recertification period following alcohol abuse is allowed and the JAA Manual of Civil Aviation Medicine gives much more detailed interpretation of the psychiatric and psychological requirements.

EAA says the broad FAA list of ''substances,'' combined with the definition of ''abuse'' and the extremely vague issue of ''physical hazard'' makes it conceivable that abuse could be held as a single misapplication of prescription medication (e.g., amphetamines, tranquilizers, sedatives, and muscle relaxants).

FAA Response: The FAA has decided to make the time periods related to substance abuse of alcohol or other substances 2 years to be consistent with substance dependence abstinence time requirements of this section and for the reasons already given. Otherwise the final rule is the same as proposed, except that §§ 67.107(b)(2), 67.207(b)(2), and 67.307(b)(2) are modified. Instead of prohibiting the ''use of a prohibited drug defined in Appendix I of part 121,'' the final rule language reads ''A verified positive drug test result acquired under any anti-drug program or internal program of the U.S. Department of Transportation or any other Administration of the U.S. Department of Transportation.'' The modified language clarifies the FAA's intention in referencing Appendix I in the proposed rule. The FAA stated in the NPRM preamble that it considers a positive drug test conducted under any rule or internal program of the Department of Transportation to be compelling proof of the use of a prohibited drug for which the drug test was positive.

The changes are intended to provide specific regulatory medical standards and enhance the agency's ability to examine and exclude from aviation a person who, though not substance dependent, manifests recurrent abuse of alcohol or other legal or illegal substances, or has a single violation of DOT drug testing programs within the preceding 2 years. These standards are consistent with the AMA Report and address national concerns about substance abuse.

In referring to use of a substance when ''physically hazardous,'' the standard generally refers to instances such as driving or flying while intoxicated or under the influence of alcohol or drugs, but could also refer to other physically hazardous situations that occurred while a person was under the influence of alcohol or legal or illegal drugs. This term is also used in DSM III and its successor DSM IV. The FAA, after careful consideration of the comments and presentations concerning substance abuse as well as the petitions and comments received to Docket Nos. 26281 and 26330, has determined that the rule as modified provides adequate notice to airmen of the required medical standards and is necessary to protect the public safety.

Neurological (§§ 67.109, 67.209, and 67.309)

The FAA proposed three changes to the neurological standards, adding ''a single seizure'' to the list of disqualifying conditions; using ''seizure'' rather than ''convulsive'' to describe potentially disqualifying conditions; and adding a ''transient loss of control of nervous system functions'' standard.

Comments: ATA, AOPA, and three AME's assert that the proposed requirement that focuses on a single seizure is burdensome and not necessary; a single mild seizure should not be the sole cause for disqualification. ATA notes that a single febrile seizure during childhood, associated with a normal electroencephalogram (EEG), neurological examination, and imaging study, does not increase the risk for further seizure activity over time. EAA suggests rather than disqualifying applicants who have had seizures, AME's be given a checklist and evaluation guide for pilots with a history of a disturbance of consciousness or neurologic function. AOPA cites common causes of single seizure events including low sodium in the blood, heat exhaustion, head injury from which the applicant entirely recovers, and eclampsia during pregnancy.

One AME asserts that the frequency of in-flight incapacitation following seizure episodes is so low as to render this change unnecessary. According to the AME, febrile seizures are common, and the

amount of increased paperwork to request special issuance of a medical certificate for individuals who have had these is simply not worth it.

USPA and AOPA say the neurological loss of control definition is too broad and is open to abuse and misinterpretation.

In response to the FAA's statement in the NPRM preamble that neither the AMA-recommended test nor the test by Folstein provides a ''useful screening device, alone or in combination, for airman neurological status,'' the AMA emphasizes the extreme importance of a test of mental fitness in attempting to ensure aviation safety and strongly recommends that the FAA designate or develop a sensitive and more specific test of mental capacity if those proposed by the AMA Report are unsatisfactory.

FAA Response: The FAA, after careful consideration of all the comments and presentations received, has decided to withdraw the proposal that specifies that a single seizure is disqualifying. The proposed standard at paragraph (a)(2) will not be added to the first-, second-, or third-class medical certificate requirements. This part of the proposal is being withdrawn because the FAA agrees with commenters that a single febrile seizure in childhood should not in most instances be disqualifying. However, any seizure that has occurred must be reported by the applicant as part of the medical history and could be found to be disqualifying under the general neurological standards of §§ 67.109(b), 67.209(b), and 67.309(b). Also, a single seizure that constitutes a disturbance of consciousness or a transient loss of control of nervous system function(s) without satisfactory medical explanation of the cause would be disqualifying under §§ 67.109(a)(2) or (3), 67.209(a)(2) or (3), and 67.309(a)(2) or (3). Under § 61.53, Operations during medical deficiency, such an occurrence would require an airman to cease exercising the privileges of any airman certificate held until medically evaluated and cleared for airman duties by the FAA.

The proposed change from ''convulsive disorder'' to ''seizure disorder'' at paragraph (b) remains in the final rule.

The FAA has determined that the addition of ''transient loss of control of nervous system functions'' should remain in the final rule. It clarifies the agency's aeromedical concern about such events whether or not they are characterized as disturbances of consciousness and allows for the identification and individual evaluation of persons with this history.

As to mental screening tests, neither the AMA Report nor the American Academy of Neurology/ American Association of Neurological Surgeons Report proposes detailed, objective criteria and tests that could be included in the standards and by which medical certification could be determined. Neither the AMA-recommended test nor the Folstein test provides a useful screening device, alone or in combination, for airman neurological status. Also, neither screening test, alone or in combination, provides predictors of skills relevant to piloting.

Cardiovascular (§§ 67.111, 67.211, and 67.311)

List of Disqualifying Conditions. The proposed rule adds to the list of disqualifying cardiovascular conditions for first-, second-, and third-class airman medical certificates an established medical history of cardiac valve replacement, permanent cardiac pacemaker implantation, and heart replacement.

Comments: None of the commenters specifically object to the disqualification for heart replacement.

Two associations, one AME, and several individuals do not support the proposal to specifically disqualify applicants with cardiac valve replacements or permanent cardiac pacemakers. One association states that the current list of disqualifying conditions is adequate. Many of these commenters say medical technology for valve replacements and pacemakers is excellent and improving, so it would be premature for the FAA to disqualify these heart conditions.

EAA says that for bioprosthetic cardiac valve patients with no signs of heart failure, arrhythmia, or atrial fibrillation, and with a normal functional capacity on stress testing, the FAA should not require the applicant to go through the special issuance process to obtain a medical certificate. According to the commenter, these individuals are at very low risk for sudden incapacitation and can perform normal activities including piloting an aircraft without undue risk. One AME believes that disqualifications for heart valve replacements should be evaluated on an individual basis.

EAA maintains that standby pacemakers or well-functioning permanent pacemakers should be allowed with a satisfactory cardiovascular evaluation and monitoring. Another commenter believes it is appropriate to deny pacemaker users first- and second-class medical certificates, but a pacemaker should not disqualify a person from a third-class medical certificate.

FAA Response: The FAA, after careful consideration of the comments and presentations received as well as the petitions and comments received to Docket Nos. 22054 and 26156, has determined that disqualifying cardiovascular conditions remain in the final rule as proposed. Further, the FAA has determined that these are serious conditions that give rise to safety concerns in the aviation environment specifically with regard to valve failure, pacemaker malfunction, progression of the underlying disease that required artificial cardiac pacing, organ rejection, or the complications of immunosuppression. As stated in the NPRM preamble, the FAA will continue to consider special issuance of medical certification on a case-by-case basis after specialized medical evaluations to confirm adequate recovery and function and the absence of significant risk in terms of the aviation environment.

These regulations clarify long-standing FAA policy. Previously, the FAA has denied medical certification to airmen with cardiac valve replacement, pacemaker implantation, or heart transplant under the current general medical standards. In the final rule, a medical history of cardiac valve replacement, pacemaker implantation, or heart transplant is disqualifying. A person with such a medical history, however, may apply for and possibly receive, a special issuance of a medical certificate. The FAA will continue to monitor medical technology in this area and will reassess these rules as developments warrant.

Blood Pressure (Proposed §§ 67.111(b), 67.211(b), and 67.311(b)). The proposed rule revises the blood pressure standards established in 1959 applicable to first-class medical certificates. The current table of age-related maximum blood pressure readings for applicants for first-class medical certificates and the reference to ''circulatory efficiency'' are deleted, and a requirement that average blood pressure while sitting not exceed 150/95 millimeters of mercury is added for applicants of all classes. A medical assessment is specified for all applicants who need or use antihypertensive medication to control blood pressure.

Comments: Four AME's support the proposed blood pressure standard, but one requests that the AME make some notation as to whether this is achieved by approved antihypertensive medication. JAA suggests further assessment of applicants whose blood pressure level is not ''consistently 160/95'' or lower.

The Boeing Employees Soaring Club, ALPA, USPA, NATA, GAPA, NAAA, three AME's, and many individual commenters do not support the proposed blood pressure standard. They say that it would increase the cost of medical care, would require costly cardiovascular work-ups for people who would not otherwise require therapy, and is not supported by medical data or accident information. Many commenters and one AME do not support the proposal because, according to these commenters, blood pressure naturally increases with age.

ALPA and Boeing Employees Soaring Club say a blood pressure reading could be affected by many factors, including time of day, daily stress, or fear of a visit to their physician, and that the FAA should not have a set blood pressure level in the rule.

AOPA, EAA, and several commenters, including doctors, say that the FAA should not disqualify persons whose blood pressure is stabilized at a lower level with therapy. According to commenters, in the NPRM the FAA implies that treated hypertension is more of a risk than the condition of high blood pressure.

FAA Response: After careful consideration of all the comments and testimony, the FAA has decided to eliminate specific blood pressure requirements in the final rule. For all classes, the final rule makes no specific reference to blood pressure but, rather, requires that the appropriate general medical standard in §§ 67.113(b), 67.213(b), and 67.313(b) be met.

The FAA has determined that a blood pressure standard is unnecessary. Each person's medical condition and treatment regimen, if any, will continue to be evaluated on an individual basis. While the use of an antihypertensive medication is not made specifically disqualifying, a person may be required to undergo further medical assessment.

Electrocardiograms (Proposed §§ 67.111 (c) and (d) and 67.211(d)); Final §§ 67.111 (b) and (c)). The NPRM proposed to add a new requirement for routine resting electrocardiograms (ECG) for second-class medical certification. Applicants would have an ECG after reaching age 35 and every 2 years after reaching age 40. An ECG requirement currently exists for first-class applicants; however, first-class applicants must have an initial ECG after the 35th birthday and annually after reaching age 40. The NPRM did not propose to add an ECG requirement for third-class applicants. The NPRM also proposed to change the validity period for an ECG to meet the requirements of a medical examination. Currently, an ECG made within 90 days before a medical examination can be used to satisfy the first-class application requirement. The proposal was to change to this to 60 days.

Comments: The AMA, ATA, JAA, and two AME's support the proposal.

ASMA, NATA, NAAA, EAA, GAPA, and ALPA do not support the proposal to require ECG's for second-class applicants. National Business Aircraft Association (NBAA), ASMA, AOPA, and EAA cite the lack of cardiac incapacitation as a causal factor in aviation accidents. Many commenters, including doctors, do not support the requirement to administer ECG tests to asymptomatic persons. Six AME's say that the ECG does not predict sudden incapacitation.

A majority of commenters stress the financial burden that ECG testing would create on those who need second-class medical certificates. According to commenters, the FAA's cost estimate for ECG's does not account for the cost to AME's of purchasing the equipment and modems to transmit the readings to the Civil Aeromedical Institute. The ECG test would also increase the amount of time an AME would spend on each pilot. AOPA notes that the FAA anticipates 1,800 applicants will not meet ECG standards, and would have to undergo the cost of additional evaluation to determine eligibility for a medical certificate. AOPA also noted that the FAA's regulatory evaluation estimated that 90 percent of these applicants would ultimately be granted medical certificates. AOPA believes the ECG requirement and follow-up testing is a waste of time and money. The Soaring Society of America suggests that an applicant's regular medical facility could perform this test and certify it to the AME, which would prevent redundant tests and lower the cost and complexity of obtaining the second-class medical certificate.

FAA Response: After careful consideration of the comments and testimony received, the FAA has decided to withdraw the proposal for an ECG requirement for second-class medical certification. There was limited support for the proposal within the medical community; and several aviation associations (including an aeromedical association), AME's, and individuals commented that the cost of implementing this proposal cannot be justified when compared with the current, limited-prognostic capabilities of the routine resting ECG.

The existing ECG requirement for first-class medical certification, an initial ECG after the 35th birthday and annual ECG's after reaching age 40, remains in the final rule. The change from 90 to 60 days for using an ECG to satisfy the first-class medical certification requirement also remains in the final rule. The FAA has determined that the ECG requirement for first-class medical certification, normally held by airline transport pilots, is consistent with the highest level of safety and is cost effective when coupled with the semi-annual examination required for that certificate. An airman holding a first-class medical certificate receives the highest level of medical scrutiny (i.e., semi-annual examination) because of the nature of his or her employment; the annual ECG is one element of this frequent, multi-factorial, medical surveillance.

Most commercial ''commuter'' operations (e.g., passenger operations of a turbojet airplane, passenger operations of an airplane having a passenger seating configuration of 10 seats or more, or passenger operations of a multiengine airplane being operated by a commuter air carrier) require pilots to have first-class medical certificates. The remaining population of commercial pilots (e.g., pilots of commuter passenger operations with airplane passenger seating configuration of 9 seats or less; flight instructors; pilots of crop dusting, banner towing, powerline, pipeline inspection operations) is required to hold a second-class medical certificate. As previously stated, the FAA has determined that biennial ECG's for these commercial pilots are not cost effective and that these pilots do not require the same level of medical scrutiny, given their employment, as pilots who are required to have a first-class medical certificate. The FAA, however, will continue to monitor and evaluate the medical/flying histories of those pilots required to have a second-class medical certificate and will, if appropriate, impose an ECG requirement in the future.

Finally, the public should be aware that the FAA uses the ECG to evaluate the medical fitness of second-class medical certificate applicants when sound medical judgment indicates that the test would be reasonable and useful. The FAA routinely requests an ECG when an individual has or may have a medical history or clinical diagnosis of a variety of medical conditions, including cardiovascular disease, hypertension, dysrhythmia, diabetes, peripheral vascular disease, cerebral vascular disease, cardiomyopathy, valvular heart disease, congenital heart disease, or a previously abnormal ECG. The FAA will continue to use the ECG as a diagnostic tool in appropriate situations.

Anticoagulant medications (Proposed §§ 67.111(c), 67.211(c), and 67.311(c)). The proposed rule adds the provision that persons applying for first-, second-, or third-class medical certificates must not use anticoagulant medication.

Comments: EAA, AOPA, two AME's, and several individuals state that the proposed rule is subject to interpretation and could, for example, include aspirin. The two AME's say that the FAA needs to differentiate between anticoagulant and antiplatelet medications regarding which are disqualifying. AOPA says disqualification should be based on the applicant's disease, not on the medicine taken, unless there are specific side effects that directly affect the safety of flight.

EAA supports the prohibition of heparin. AOPA says coumadin use should not be disqualifying, since its track record is well established.

FAA Response: The FAA did not intend for antiplatelet medications (e.g., aspirin) to be included as anticoagulants. After careful consideration of the comments and testimony received, the FAA has decided to withdraw the proposal to add anticoagulant use as a specifically disqualifying medication since the use of these medications could be found disqualifying in this final rule under paragraph (c) of the general medical condition section (see §§ 67.113(c), 67.213(c), and 67.313(c)), of part 67.

Cholesterol Testing (Proposed § 67.111(f))

The current rule contains no cholesterol standards. The proposed rule adds a new total blood cholesterol testing requirement for first-class applicants after they reach age 50, and annually thereafter. A blood cholesterol level of 300 milligrams per deciliter or more requires applicants to undergo further evaluation. If otherwise eligible, the applicant would be issued a medical certificate pending results of the evaluation.

Comments: The vast majority of individual commenters, as well as NBAA, AOPA, ASMA, and EAA, do not support the proposed requirement for total blood cholesterol determination for first-class medical certification. AOPA, NATA, and ALPA say some individuals believe that the test is invasive and a personal health matter to be discussed with a private physician, not with the FAA. AOPA, EAA, two AME's, and several individuals say factors other than total cholesterol contribute to coronary artery disease. Since the AMA study, Allied Pilots Association (APA), EAA, two AME's and several others note, high density lipoprotein (HDL) and low density lipoprotein (LDL) have been found to better correlate with coronary artery disease (CAD) than total cholesterol.

Nearly half of the AME commenters state that cholesterol testing is not needed because it does not predict an applicant's ability to perform safely. One AME notes that 50 percent of all myocardial infarctions occur in people with cholesterol ranging between 180 and 220, levels well below the FAA's proposed evaluation threshold of 300. NBAA and APA say the link between incidence of high serum cholesterol and aircraft accidents caused by pilot incapacitation is tenuous at best. APA suggests that the FAA consider reviewing cardiovascular risk factors every 3–5 years to develop other, more appropriate measures of cardiovascular risk.

FAA Response: After careful consideration of the comments and testimony received, the FAA has decided to withdraw the proposal to measure the total cholesterol of applicants for first-class medical certification. Several aviation associations, AME's, and individuals commented that there is no scientific evidence that demonstrates the relationship between a specific cholesterol value and the existence of identifiable pathology that represents a threat to aviation safety. Commenters pointed out that a different understanding exists today about total cholesterol level, per se, and pathology compared to when the data that supported the original proposal were compiled. Cholesterol testing, as proposed, is not cost effective. The FAA encourages airmen to have their lipid levels checked as a health measure but is not requiring airmen to do so in the final rule.

Diabetes (§§ 67.113(a), 67.213(a), and 67.313(a))

No change is proposed to the standards concerning airmen with diabetes, currently set forth in paragraph (f)(1) of §§ 67.13, 67.15, and 67.17. In the preamble to the proposed rule, however, FAA states that it has determined that persons who do not meet the medical standard because their diabetes requires oral hypoglycemic drugs would no longer be categorically denied special issuance of airman medical certification. This policy would apply to individuals whose diabetes is without complications and acceptably controlled by diet and oral drugs with appropriate monitoring and other conditions. However, this policy change does not affect the long-standing FAA policy and practice that a diabetic using insulin for control is not eligible for unrestricted or restricted medical certification.

Comments: Two AME's believe that insulin-dependent diabetics should not be allowed any type of pilot's license.

USPA says insulin-dependent diabetics should be acceptable on a case-by-case basis. One commenter believes that diabetic private or recreational pilots should be certificated if their diabetes is under good control.

EAA, two other AME's, and many individuals support permitting noninsulin-dependent diabetics to obtain special issuance.

A few commenters state that it is unrealistic to exclude all users of hypoglycemic drugs, as proposed in the NPRM. One diabetic noted that 50 percent of men over 65 have ''Diabetes II,'' which does not require insulin or anything other than a mild drug.

FAA Response: After careful consideration of the comments and testimony received as well as the petitions and comments received to docket Nos. 26281 and 26493, the FAA has determined that the current consensus of the medical community supports the FAA position. Many individuals who are not insulin-treated diabetics can, with appropriate monitoring and other conditions, receive a special issuance of their medical certificates to perform the duties authorized by their class of medical certificate without endangering public safety. The final rule is the same as the current rule.

Also, the FAA has determined that, rather than engaging in rulemaking concerning diabetes, it is more appropriate to reexamine its policy on special issuance of medical certificates to persons with insulin-treated diabetes mellitus. On December 29, 1994, subsequent to publication of the NPRM, the Federal Air Surgeon requested comments on a possible policy change with respect to individuals who have a clinical diagnosis of insulin-treated diabetes mellitus (59 FR 67246, December 29, 1994). The docket for this notice closed on March 29, 1995. The FAA will review the comments and testimony received in Docket Nos. 26493 and 27940 concerning diabetes and will publish in a separate notice the agency's determination concerning its policy on special issuance of medical certificates to persons with insulin-treated diabetes mellitus.

Special Issuance (§ 67.401)

Proposed § 67.401(a) limits the duration of any medical certificate issued under the special issuance procedures of this section to the duration of an Authorization for special issuance. When the Authorization expires, or if the FAA withdraws the Authorization, the medical certificate issued pursuant to that Authorization also expires.

Comments: AOPA and IPA say that the extra requirements for special issuance procedures should be withdrawn because they will increase the burden on FAA to write exceptions (especially in a time of government budget cutting and staff reductions), and because applicants will have to pay more and bet their livelihood with each reaffirmation request.

FAA Response: The FAA, after careful consideration of all the comments and testimony received as well as the petitions and comments received to Docket No. 25787, has decided to retain the requirement limiting duration of any class medical certificate to the duration of an Authorization. This will ensure that the medical justification for the special issuance remains valid and the holder of the special issuance undergoes appropriate periodic reevaluation. This change explicitly connects the duration of any special issuance medical certificate to the validity of the document upon which it is based and requires periodic requests for reissuance. The FAA foresees no significant additional administrative burden on the FAA.

The FAA has included specific requirements for an Authorization in the rule language in order to provide procedures for legal documentation and control of validity periods, followup requirements, withdrawals, and functional or operational limitations.

Incorrect Statements by Applicants (§ 67.401(f)(5) and 67.403(c))

The proposed rule broadens the regulatory basis for action when an applicant or airman provides incorrect information when applying for medical certification. Proposed §§ 67.401(f)(5) and 67.403(c) would allow the FAA the option of denying, suspending, or revoking an airman medical certificate and denying or withdrawing an Authorization or SODA, not only when the holder makes a fraudulent or intentionally false statement, but also when the holder makes an incorrect statement in support of a request for a medical certificate, an Authorization, or SODA or in an entry in any logbook, record, or report that is kept, made, or used to show compliance with the medical certificate, Authorization, or SODA. A suspension, revocation, or withdrawal could occur even if the person did not knowingly make the incorrect statement or entry.

Comments: One AME supports the Authorization and SODA withdrawal proposals.

EAA says the proposed § 67.403(c) statement concerning unknowingly false statements should only call for a review of the medical certificate and possible revocation, if warranted by the corrected information. AOPA notes that the Federal Aviation Act says applicants denied issuance or renewal of a certificate may have an NTSB hearing.

NATCA, IPA, APA, four AME's, and a large number of individual commenters are concerned about what they view as the lack of due process in the decision to withdraw the Authorization. According to these commenters, many innocent errors are made on the applications due to the applicant's unclear memory or misunderstanding of terms on the application. These commenters suggest that the FAA require the AME to contact the pilot and provide a chance to explain and correct the incorrect statements. Commenters say that the wording creates too ambiguous an authority for the FAA and creates the potential for action by the FAA against almost any pilot. Some associations are concerned that individuals whose

applications or certificates are denied may actually lose their jobs without benefit of an opportunity to clarify unintentional discrepancies.

FAA Response: The FAA noted in the preamble to the NPRM its concern that medical certification based on incorrect medical data may be inappropriate in the light of the true data. The current regulations do not explicitly provide for withdrawal of an Authorization or SODA or suspension or revocation of a medical certificate when unknowingly incorrect statements are relied upon in the FAA's decision to issue an Authorization, SODA, or medical certificate. The FAA's intent in including language on incorrect statements is to provide a basis for appropriate action when a person provides such unknowingly incorrect information that is relied on by the agency in its decision. The withdrawal, suspension, or revocation in this case is not meant to be punitive, but rather corrects the inappropriate granting of an Authorization, SODA, or medical certificate. The final rule clarifies the FAA's intent by including language in § 67.403(c) that limits the reference to ''incorrect statements'' to those ''upon which the FAA relied.''

Return of Medical Certificate (§§ 67.401(i)(4) and 67.415)

Proposed § 67.401(i)(4) requires surrender to the Administrator of a medical certificate rendered invalid pursuant to a withdrawal in accordance with § 67.401(a). The proposal also adds a requirement in § 67.415 to specify that the holder of a medical certificate that is suspended or revoked must return the medical certificate to the Administrator.

Comments: EAA says that presently airmen are not required to return their medical certificates without a hearing before the NTSB; procedures now exist for emergency suspension or revocation of a certificate based on false information. Therefore, EAA believes there is no need for this requirement. Three AME's believe that the added requirement for mandatory return of a medical certificate at the request of the Administrator would open the whole process of medical certification to potential abuse by the FAA and should be deleted. Several individuals state that this provision is unnecessary and should be withdrawn; the current rules are sufficient to ensure that pilots fly only with a valid medical certificate.

FAA Response: Current § 67.27(g) provides that the holder of a medical certificate shall surrender it, upon request of the FAA, if its issuance is wholly or partly reversed upon reconsideration. After careful consideration of all the comments and testimony received, the FAA has determined that the language, as proposed, codifies existing practice, parallels the procedures with airman certificates, and clarifies the FAA's intent to require the return of medical certificates that have become invalid. The retention by an airman of an invalid medical certificate is not consistent with proper and efficient enforcement of safety regulations because of the apparent authority of these documents. Inclusion of this requirement, however, does not in any way affect the certificate holder's administrative review or appeal rights.

Regulatory Evaluation Summary

Introduction

Changes to Federal regulations must undergo several economic analyses. First, Executive Order 12866 directs Federal agencies to promulgate new regulations or modify existing regulations only if the potential benefits to society justify its costs. Second, the Regulatory Flexibility Act of 1980 requires agencies to analyze the economic impact of regulatory changes on small entities. Finally, the Office of Management and Budget directs agencies to assess the effects of regulatory changes on international trade. In conducting these assessments, the FAA has determined that this rule: (1) Will generate benefits exceeding its costs and is not ''significant'' as defined in Executive Order 12866; (2) is not ''significant'' as defined in DOT's Policies and Procedures; (3) will not have a significant impact on a substantial number of small entities; and (4) will not constitute a barrier to international trade. These analyses, available in the docket, are summarized below.

The majority of the amendments will have insignificant attributable costs and benefits. This evaluation does not address the minor amendments such as changes in syntax, technical corrections, reorganization, updating medical terminology, or adjustments to cross references for conformance purposes.

Furthermore, the evaluation attributes no significant costs or benefits to several other amendments that add a specific disease or medical condition to the list of medical standards. Such additions do not necessarily constitute a change in the standards. Existing regulations include three open-ended (general) medical standards that cover:

> (1) any other personality disorder, neurosis, or mental condition . . ., (2) any other organic, functional, or structural disease, defect, or limitation . . ., and (3) no medication or other treatment . . . .

that the Federal Air Surgeon finds would make, or may reasonably be expected to make, the applicant unable to perform the duties associated with the airman certificate. Thus, the applicable medical standards

are not limited to those actually listed in the regulation. As medical knowledge and experience progress, the Federal Air Surgeon may find a previously unlisted disease or condition to be grounds for withholding or restricting a medical certificate, so long as that finding is based on qualified medical judgment.

The addition of specifically disqualifying medical conditions under the amended standards could cause a small number of airmen, who currently hold medical certificates as a result of an order of the National Transportation Safety Board (NTSB) to be disqualified from further medical certification. These airmen were denied medical certification by the FAA under the current general medical standards. For example, the FAA has denied medical certification to airmen who have had cardiac valve replacement and the NTSB has ordered medical certification in some of these cases. Under the amended standards a medical history of cardiac valve replacement is specifically disqualifying and those airmen will no longer be entitled to medical certification. It is expected, however, that medical certification of the affected individuals will continue under the Federal Air Surgeon's special issuance authority once the FAA evaluates the case and is satisfied that the airman's condition has not worsened since the NTSB ordered medical certification. As such, the expected economic impact of the specifically disqualifying medical conditions will be minor.

Discussion of Comments Addressing Economic Evaluation

This section of the summary responds to comments concerning the economic evaluation of the NPRM. The NPRM for this rule included five significant proposals that were withdrawn after careful consideration of the comments received. This section notes, but does not address comments concerning the regulatory evaluation of the withdrawn proposals, since such comments are no longer pertinent.

Comment: The U.S. Small Business Administration (SBA) states in its comment that the FAA's regulatory flexibility analysis for the NPRM does not conform to the Regulatory Flexibility Act (RFA), and that a proper regulatory flexibility analysis must be performed prior to issuing a final rule.

FAA Response: The FAA does not agree. Federal agencies are required to prepare a regulatory flexibility analysis only if the proposed rule would have a significant economic impact on a substantial number of small entities.[1] The NPRM would not have had such impact and this was stated. The SBA also notes that no explanation was provided to support that determination. The FAA agrees and provides the following table of explanation.

Medical certification category	NPRM 10-year present value	NPRM annualized costs	Active airmen	Average cost per year per active airman
First-class	$5,700,000	$811,551	147,676	$5.50
Second-class	22,700,000	3,231,969	173,435	18.64
Third-class	5,600,000	797,314	325,996	2.45

As shown above, the average annualized cost impact of the proposed rule would have ranged from $2.45 to $18.64 per person subject to medical certification requirements. It would be statistically impossible for the impact of the proposed rule to exceed these averages to such an extent as to have a significant impact (multiple thousands of dollars annually depending on the entity type) on a substantial number (at least one-third) of small entities; even if the rule only affected small entities. Similarly, since the costs of the final rule are approximately 20 percent of the NPRM costs, it follows that the final rule also will not have a significant economic impact on a substantial number of small entities.

Comments: Several associations and numerous individual commenters find it illogical to draw inferences for pilots from the air traffic controllers who were monitored in the Johns Hopkins study. The reasons cited by the commenters include air traffic control (ATC) work is inherently stressful, ATC work is sedentary, controllers are exposed to cathode ray tube monitors and indoor air, controllers have a history of strife between labor and management, and they work on varying shifts.

FAA Response: The FAA disagrees. The Hopkins study was expressly used to quantify the relative differences of primary pathology incidence across age cohorts. The Hopkins results are conclusively supported by other general medical investigation as well as the FAA's own medical certification data for pathology incidence and application denials.

[1] *A Guide to Federal Agency Rulemaking,* 2nd edition; Administrative Conference of the United States; 1991; p. 162.

Comments: Four national aviation associations strongly disagree with the NPRM proposal to reduce the duration of third-class medical certificates for persons age 70 and older. The commenters assert that the benefits have not been demonstrated and that the statistical analysis FAA used to confirm that the incidence of pathology related accidents increases with age is supported by an insufficient sample size.

FAA Response: After careful consideration of the testimony and comments received, the FAA has withdrawn this proposed provision.

Comments: Numerous individual commenters stated that the proposed higher standards for blood pressure would prove costly to pilots with borderline pressure measurements and that the affected individuals would be required to take extensive additional testing.

FAA Response: After careful consideration of the testimony and comments received, the FAA has withdrawn this proposed provision.

Comments: Six major associations disagree with the provision for electrocardiograms, second class and assert that the frequency of medically related aviation accidents, the majority of which are not predictable, does not support the administrative and economic burdens that would be imposed on the affected applicants. Two associations assert that the 40-percent effectiveness level that was assumed in the evaluation is questionable and is a significant error in the cost-benefit analysis. Five associations, two AME's, and numerous individual commenters state that the FAA's cost estimate does not account for the cost for AME's to purchase the necessary medical equipment and modems. They warn that some AME's may withdraw their participation rather than incur the additional costs.

FAA Response: After careful consideration of the testimony and comments received, the FAA has withdrawn this proposed provision.

Comments: Several associations assert that requiring a cholesterol test would be a significant administrative and cost burden. One association stated that the regulatory evaluation employed an average laboratory test cost of $10, but that costs range between $15 and $16 in the Washington, D.C. area. One individual commenter asserts that the cost-benefit analysis is flawed because it based cost savings on a cholesterol level lower than 300, and because the analysis assumed that all heart attacks studied represented individuals with critically high cholesterol.

FAA Response: After careful consideration of the testimony and comments received, the FAA has withdrawn this proposed provision.

Comments: One major association states that the addition of the intermediate vision, first and second class is unnecessary and unwarranted, and that it would add costs with no significant safety benefit.

FAA Response: The FAA does not agree. The evaluation estimated that the direct testing costs, including applicant time, would range from $1.30 to $3.86 per year per applicant age 50 and older. Additional costs (for glasses and examinations) would only be incurred by those persons whose intermediate vision was, in fact, deficient, and who could not satisfactorily read their flight instruments. The FAA maintains that these costs are not unreasonable, and that the benefits of commercial pilots being able to read flight instruments are conclusive.

Costs and Benefits That Are Not Quantified

Prior to summarizing the evaluation of the substantive provisions, it is important to note one category of costs and one category of benefits that have not been quantified in this analysis. The evaluation does not explicitly quantify the economic consequences to those individuals who could lose their pilot medical certificate privileges as a result of the additional medical tests or standards. Where such consequences are expected, the evaluation estimates the numbers of persons who may be denied but does not attribute a cost to those actions.

It is recognized that the denial of pilot privileges could mean the loss of a highly valued avocation for some individuals. For others, it could actually result in the loss of primary livelihood. An accurate assessment of the economic valuation of the denials that are projected under the rule is beyond the scope of the evaluation.

At the same time, the evaluation also does not quantify the overwhelming personal health benefits, external to flight safety, that will be afforded to those individuals whose medical conditions will be detected and whose treatment will be enabled by the new tests and standards. On average, third-class medical certificate holders spend only 0.7 percent of their time flying. The evaluation only quantifies the direct benefits of the rule to reduced aviation accidents.

Under existing regulations, the Federal Air Surgeon is charged to deny a medical certificate in those cases where a disease or other physical or mental condition would make, or may be reasonably be expected to make, the applicant unable to perform the duties associated with the medical certificate. Such findings are not capricious, but instead, are based on the case history of the individual and on appropriate, qualified medical judgment. The FAA holds that the severity of a disease or medical condition necessary to warrant a denial is such that the aviation safety and personal health benefits of that action will always exceed the costs associated with the loss of pilot privilege.

Summary of Quantified Costs and Benefits

Vision Amendments, All Classes. The final rule institutes additional vision tests and standards for all three classes. For first- and second-class medical certificate applicants age 50 and older, it adds a new standard (20/40 or better, Snellen equivalent) and a new test for intermediate vision (near vision at 32 inches). Applicants for third-class medical certificates will be subject to a new standard (20/40 or better) and a new test for near vision (16 inches).

The projected 10-year costs of the intermediate vision amendment for first-class medical certificate applicants are: (1) $1.4 million in primary testing costs, (2) $2.1 million in follow-up compliance costs (examinations and glasses) for those persons who would not meet the standard, and (3) $6,147 in direct processing costs for the expected 15 additional persons who could be denied under the provision. In total, it is expected that the intermediate vision amendment for first-class medical certificate applicants would impose an incremental 10-year cost of $3.5 million, with a 1995 present value of $2.5 million.

The projected 10-year costs of the intermediate vision amendment for second-class medical certificate applicants are: (1) $442,224 in primary testing costs, (2) $2.0 million in follow-up compliance costs (examinations and glasses) for those persons who would not meet the standard, and (3) $6,626 in direct processing costs for the expected 17 additional persons who would be denied under the provision. In total, it is expected that the intermediate vision amendment for second-class medical certificate applicants would impose an incremental 10-year cost of $2.4 million, with a 1995 present value of $1.7 million.

The projected 10-year costs of the near vision amendment for third-class medical certificate applicants are: (1) $2.3 million in primary testing costs, (2) $1.1 million in follow-up compliance costs (examinations and glasses) for those persons who would not meet the standard, and (3) $129,690 in direct processing costs for the expected 330 additional persons who would be denied under the provision. In total, it is expected that the near vision amendment for third-class medical certificate applicants would impose an incremental 10-year cost of $3.5 million, with a 1995 present value of $2.5 million. It is emphasized that the denials and costs associated with the near vision requirement are not wholly attributable to the amendment. Although this requirement does not exist in current regulations, the requirement has been in place administratively for some time. Thus, the associated costs are being and would continue to be incurred without this amendment. The economic evaluation of this requirement is provided as information to assess the fact the requirement would explicitly be added to the regulations.

In assessing the benefits of the vision amendments, NTSB accident records were investigated for the periods from 1962 through 1989 for commercial flights and from 1982 through 1989 for general aviation. For these periods, no accident was found where intermediate or near vision deficiency was specifically determined to be the cause. As such, the FAA is not able to quantitatively ascribe the benefits of the three vision amendments based solely on historical accident analysis.

Notwithstanding the absence of documented accidents related to these three provisions, the FAA maintains that such accidents may well have occurred and would continue to occur in the absence of the amendments. The NTSB accident analysis system may not document those cases where a near or intermediate vision problem caused or contributed to accidents. Examples would include deviations from course or altitude, inaccurate monitoring of gauges and other avionics displays, and incorrect setting of aeronautical parameters such as headings or radio frequencies.

While the extent to which intermediate or near vision problems have caused such accidents is unknown, it is the FAA's position that: (1) general aviation pilots require adequate near vision to read charts and checklists, and (2) commercial pilots require adequate intermediate vision to properly monitor aircraft instruments. Although this evaluation is not able to quantify the benefits of the vision amendments, the FAA holds that the benefits will be significant and will exceed the expected costs.

Part 61, Medical Certificate Validity Period, Third-Class. Under the final rule, persons under age 40 will generally only be required to undergo a physical examination every 3 years. Medical certificates for persons age 40 and older will continue to be valid for 2 years.

Other than minor administrative costs to effect the new procedure, there will be no direct expenditures associated with the amendment. In addition, careful consideration of all comments and testimony received,

as well as the petitions and comments received to Docket Nos. 24932, 26281, and 27473, leads the FAA to conclude that extending the duration between medical examinations can be done with no detriment to safety in the case of younger airmen, who are much less likely to suffer medical incapacitation.

The FAA has investigated the relative primary pathology incidence rates for persons under and over 40 years of age. As a group, persons under age 40 exhibit 1/27 of the pathology incidence rate of persons 40 and older. Even weighting these rates, by the numbers of pilots by age class, results in an ''under age 40'' incidence equal to 1/6 that of third-class medical certificate applicants age 40 and older.

The FAA's position on this issue is further supported by a review of the pertinent accident data. National Transportation Safety Board (NTSB) data were reviewed for the period 1982 through 1989. During that period, 259 pathology related, general aviation accidents occurred. Only two of those accidents, however, involved private pilots under age 40 with a potentially detectable primary pathology. One case involved a 37-year-old pilot with a valid medical certificate who suffered a heart attack that had not been predicted. The second accident involved a 25-year-old with a vasovagal syncope who was flying without a medical certificate.

As with all age groups, those individuals under age 40 manifesting conditions that represent a risk to safety will be denied medical certification or, if they apply for and receive a special issuance of a medical certificate, will be restricted in their flying activities and/or examined more thoroughly and frequently.

The primary benefits of this amended provision will derive from the annual reduction in third-class medical certificate applications. FAA compared the projected numbers of applications under the existing 2 year duration for all ages, against the applications that are expected under the final rule provision extending the duration for persons under age 40 to 3 years. Applications under the final rule were computed by reducing the projected applications for persons under age 40 by a factor of two-thirds. Over the 10-year study period, the part 61 provision is expected to reduce applications by 268,000.

Each avoided examination is valued at $89, consisting of $50 in direct testing costs, and one and one-half hours of the applicant's time valued at $29 per hour. This produces an expected 10-year savings of $23.9 million, with a 1995 present value of $16.7 million, not counting FAA processing costs.

Regulatory Flexibility Determination

The Regulatory Flexibility Act of 1980 (RFA) was enacted by Congress to ensure that small entities are not unnecessarily or disproportionately burdened by Government regulations. The RFA requires a Regulatory Flexibility Analysis if a rule would have a significant economic impact, either detrimental or beneficial, on a substantial number of small entities. FAA Order 2100.14A, Regulatory Flexibility Criteria and Guidance, provides threshold cost and small entity size standards for complying with RFA review requirements in FAA rulemaking actions.

The rule is estimated to have a 10 year, 1995 present value cost of $6.6 million, which equates to an annualized cost of $940,000 to the approximately 647,100 active airmen. The average annualized effect per airman is projected to equal $1.45. In light of this information, the FAA finds that the amendment will not have a significant economic impact on a substantial number of small entities.

International Trade Impact Assessment

The final rule will have little or no impact on trade for both U.S. firms doing business in foreign countries and foreign firms doing business in the United States.

Federalism Implications

The regulations herein would not have substantial direct effects on the states, on the relationship between the national government and the states, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12866, it is determined that this rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Conclusion

For the reasons discussed in the preamble, and based on the findings in the Regulatory Evaluation and the International Trade Impact Analysis, the FAA has determined that this rule is not major under Executive Order 12866. In addition, the FAA certifies that this rule will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. This rule is considered significant under DOT Regulatory Policies and Procedures (44

FR 11034; February 26, 1979). A regulatory evaluation of the rule, including a Regulatory Flexibility Determination and Trade Impact Analysis, has been placed in Docket 27940. A copy may be obtained by contacting the person identified under ''FOR FURTHER INFORMATION CONTACT.''

Paperwork Reduction Act

The paperwork burden associated with part 67 is currently approved under OMB number 2120–0034. There is small reduction in paperwork associated with this final rule.

Derivation and Distribution Tables

The Derivation Table below shows the source in current part 67 on which each paragraph of each section of revised part 67 is based. The Distribution Table below shows where each current part 67 section and paragraph can be found in the revised part 67.

Derivation Table

Revised section	*Based On*
	Subpart A
Section	
67.1	Current §§ 67.1 and 67.21.
67.3	Current § 67.11.
67.5	Current § 67.12.
67.7	Current § 67.3.
	Subpart B
Section	
67.101	Current § 67.13(a) and new language.
67.103(a)	Current § 67.13(b)(1).
67.103(b)	Current § 67.13(b)(2) and new language.
67.103(c)	Current § 67.13(b)(3) and new language.
67.103(d)	Current § 67.13(b)(4).
67.103(e)	Current § 67.13(b)(5).
67.103(f)	Current § 67.13(b)(6) and flush paragraph.
67.105(a)	Current § 67.13(c)(1) and new language.
67.105(b)	Current § 67.13(c)(2), (c)(3), (c)(4), (c)(5), and new language.
67.105(c)	Current § 67.13(c)(6) and new language.
67.107(a)	Current § 67.13(d)(1)(i) and new language.
67.107(b)	New language.
67.107(c)	Current § 67.13(d)(1)(ii) reordered.
67.109(a)	Current § 67.13(d)(2)(i) and new language.
67.109(b)	Current § 67.13(d)(2)(ii).
67.111(a)	Current § 67.13(e)(1) and new language.
67.111(b)	Current § 67.13(e)(2) and (3) and new language.
67.111(c)	Flush paragraph after current § 67.13(e)(5) as modified.
67.113(a)	Current § 67.13(f)(1).
67.113(b)	Current § 67.13(f)(2).
67.113(c)	Current § 67.13(f)(3), added September 9, 1994.
67.115	Current § 67.13(g).
	Subpart C
Section	
67.201	Current § 67.15(a) and new language.
67.203(a)	Current § 67.15(b)(1).
67.203(b)	Current § 67.15(b)(2) and new language.
67.203(c)	Current § 67.15(b)(5) and new language.
67.203(d)	Current § 67.15(b)(3).
67.203(e)	Current § 67.15(b)(4) and new language.
67.203(f)	Current § 67.15(b)(6) and flush paragraph.
67.205(a)	Current § 67.15(c)(1) and new language.
67.205(b)	Current § 67.15(c)(2), (c)(3), (c)(4), (c)(5), and new language.
67.205(c)	Current § 67.15(c)(6) and new language.
67.207(a)	Current § 67.15(d)(1)(i) and new language.

Derivation Table—Continued

Revised section	*Based On*
67.207(b)	New language.
67.207(c)	Current § 67.15(d)(1)(ii) reordered.
67.209(a)	Current § 67.15(d)(2)(i) and new language.
67.209(b)	Current § 67.15(d)(2)(ii) and new language.
67.211	Current § 67.15(e)(1) and new language.
67.213(a)	Current § 67.15(f)(1).
67.213(b)	Current § 67.15(f)(2).
67.213(c)	Current § 67.15(f)(3), added September 9, 1994.
67.215	Current § 67.15(g).
	Subpart D
Section	
67.301	Current § 67.17(a) and new language.
67.303(a)	Current § 67.17(b)(1) and new language.
67.303(b)	New language.
67.303(c)	Current § 67.17(b)(3) and new language.
67.303(d)	Current § 67.17(b)(2) and new language.
67.305(a)	Current § 67.17(c)(1) and new language.
67.305(b)	Current § 67.17(c)(2) and (3), and new language.
67.305(c)	Current § 67.17(c)(4) and new language.
67.307(a)	Current § 67.17(d)(1)(i) and new language.
67.307(b)	New language.
67.307(c)	Current § 67.17(d)(1)(ii) reordered.
67.309(a)	Current § 67.17(d)(2)(i) and new language.
67.309(b)	Current § 67.17(d)(2)(ii) and new language.
67.311	Current § 67.17(e)(1) and new language.
67.313(a)	Current § 67.17(f)(1).
67.313(b)	Current § 67.17(f)(2).
67.313(c)	Current § 67.17(f)(3), added September 9, 1994.
67.315	Current § 67.17(g).
	Subpart E
Section	
67.401(a)	Current § 67.19(a) and new language.
67.401(b)	New language.
67.401(c)	Current § 67.19(b).
67.401(d)	Current § 67.19(d) and new language.
67.401(e)	Current § 67.19(c).
67.401(f)	New language.
67.401(g)	Current § 67.19(e) and new language.
67.401(h)	Current § 67.19(f) and new language.
67.401(i)	New language.
67.401(j)	New language.
67.403(a)	Current § 67.20(a) and new language.
67.403(b)	Current § 67.20(b) and new language.
67.403(c)	New language.
67.405(a)	Current § 67.23(a).
67.405(b)	Current § 67.23(b).
67.407(a)	Current § 67.25(a) and new language.
67.407(b)	Current § 67.25(a) flush paragraph and new language.
67.407(c)	Current § 67.25(b), as amended September 9, 1994, and new language.
67.407(d)	Current § 67.25(c).
67.409(a)	Current § 67.27(a).
67.409(b)	Current § 67.27(b), as amended September 9, 1994.
67.409(c)	Current § 67.27(c).
67.409(d)	Current § 67.27(d).
67.411(a)	Current § 67.29(a).
67.411(b)	Current § 67.29(b).
67.411(c)	Current § 67.29(c).

Derivation Table—Continued

Revised section	*Based On*
67.413(a)	Current § 67.31.
67.413(b)	New language.
67.415	New language.

Distribution Table

Current Section	*Revised Section*
	Subpart A
Section	
67.1	§ 67.1.
67.3	§ 67.7.
67.11	§ 67.3.
67.12	§ 67.5.
67.13(a)	§ 67.101.
67.13(b)	§ 67.103.
67.13(c)	§ 67.105.
67.13(d)	§ 67.107 and § 67.109.
67.13(e)	§ 67.111 and § 67.113(b).
67.13(f)	§ 67.113.
67.13(g)	§ 67.115.
67.15(a)	§ 67.201.
67.15(b)	§ 67.203.
67.15(c)	§ 67.205.
67.15(d)	§ 67.207 and § 67.209.
67.15(e)	§ 67.211.
67.15(f)	§ 67.213.
67.15(g)	§ 67.215.
67.17(a)	§ 67.301.
67.17(b)	§ 67.303.
67.17(c)	§ 67.305.
67.17(d)	§ 67.307 and § 67.309.
67.17(e)	§ 67.311.
67.17(f)	§ 67.313.
67.17(g)	§ 67.315.
67.19	§ 67.401.
67.20	§ 67.403.
	Subpart B
Section	
67.21	§ 67.1.
67.23	§ 67.405.
67.25	§ 67.407.
67.27	§ 67.409.
67.29	§ 67.411.
67.31	§ 67.413.

The Amendments

In consideration of the foregoing, the Federal Aviation Administration amends parts 61 and 67 of Title 14 Code of Federal Regulations (14 CFR parts 61 and 67) effective September 16, 1996.

The authority citation for part 67 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701–44703, 44707, 44709–44711, 45102–45103, 45301–45303.

Part 67—Medical Standards and Certification
Subpart A—General

Source: Docket No. 1179 (27 FR 7980, 8/10/62) effective 11/1/62 unless otherwise indicated; [(Docket No. 27940, Amdt. 67–17, Eff. 9/16/96 (61 FR 11238, 3/19/96)]

§ 67.1 Applicability.

This part prescribes the medical standards and certification procedures for issuing medical certificates for airmen and for remaining eligible for a medical certificate.

§ 67.3 Issue.

Except as provided in § 67.5, a person who meets the medical standards prescribed in this part, based on medical examination and evaluation of the person's history and condition, is entitled to an appropriate medical certificate.

§ 67.5 Certification of foreign airmen.

A person who is neither a United States citizen nor a resident alien is issued a certificate under this part, outside the United States, only when the Administrator finds that the certificate is needed for operation of a U.S.-registered aircraft.

§ 67.7 Access to the National Driver Register.

At the time of application for a certificate issued under this part, each person who applies for a medical certificate shall execute an express consent form authorizing the Administrator to request the chief driver licensing official of any state designated by the Administrator to transmit information contained in the National Driver Register about the person to the Administrator. The Administrator shall make information received from the National Driver Register, if any, available on request to the person for review and written comment.

Subpart B—First-Class Airman Medical Certificate

§ 67.101 Eligibility.

To be eligible for a first-class airman medical certificate, and to remain eligible for a first-class airman medical certificate, a person must meet the requirements of this subpart.

§ 67.103 Eye.

Eye standards for a first-class airman medical certificate are:

(a) Distant visual acuity of 20/20 or better in each eye separately, with or without corrective lenses. If corrective lenses (spectacles or contact lenses) are necessary for 20/20 vision, the person may be eligible only on the condition that corrective lenses are worn while exercising the privileges of an airman certificate.

(b) Near vision of 20/40 or better, Snellen equivalent, at 16 inches in each eye separately, with or without corrective lenses. If age 50 or older, near vision of 20/40 or better, Snellen equivalent, at both 16 inches and 32 inches in each eye separately, with or without corrective lenses.

(c) Ability to perceive those colors necessary for the safe performance of airman duties.

(d) Normal fields of vision.

(e) No acute or chronic pathological condition of either eye or adnexa that interferes with the proper function of an eye, that may reasonably be expected to progress to that degree, or that may reasonably be expected to be aggravated by flying.

(f) Bifoveal fixation and vergence-phoria relationship sufficient to prevent a break in fusion under conditions that may reasonably be expected to occur in performing airman duties. Tests for the factors named in this paragraph are not required except for persons found to have more than 1 prism diopter of hyperphoria, 6 prism diopters of esophoria, or 6 prism diopters of exophoria. If any of these values are exceeded, the Federal Air Surgeon may require the person to be examined by a qualified eye specialist to determine if there is bifoveal fixation and an adequate vergence-phoria relationship. However, if otherwise eligible, the person is issued a medical certificate pending the results of the examination.

§ 67.105 Ear, nose, throat, and equilibrium.

Ear, nose, throat, and equilibrium standards for a first-class airman medical certificate are:

(a) The person shall demonstrate acceptable hearing by at least one of the following tests:

(1) Demonstrate an ability to hear an average conversational voice in a quiet room, using both ears, at a distance of 6 feet from the examiner, with the back turned to the examiner.

(2) Demonstrate an acceptable understanding of speech as determined by audiometric speech discrimination testing to a score of at least 70 percent obtained in one ear or in a sound field environment.

(3) Provide acceptable results of pure tone audiometric testing of unaided hearing acuity according to the following table of worst acceptable thresholds, using the calibration standards of the American National Standards Institute, 1969 (11 West 42d Street, New York, NY 10036):

Frequency (Hz)	500 Hz	1000 Hz	2000 Hz	3000 Hz
Better ear (Db)	35	30	30	40
Poorer ear (Db)	35	50	50	60

(b) No disease or condition of the middle or internal ear, nose, oral cavity, pharynx, or larynx that—

(1) Interferes with, or is aggravated by, flying or may reasonably be expected to do so; or

(2) Interferes with, or may reasonably be expected to interfere with, clear and effective speech communication.

(c) No disease or condition manifested by, or that may reasonably be expected to be manifested by, vertigo or a disturbance of equilibrium.

§ 67.107 Mental.

Mental standards for a first-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of any of the following:

(1) A personality disorder that is severe enough to have repeatedly manifested itself by overt acts.

(2) A psychosis. As used in this section, ''psychosis'' refers to a mental disorder in which:

(i) The individual has manifested delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition; or

(ii) The individual may reasonably be expected to manifest delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition.

(3) A bipolar disorder.

(4) Substance dependence, except where there is established clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including sustained total abstinence from the substance(s) for not less than the preceding 2 years. As used in this section—

(i) ''Substance'' includes: Alcohol; other sedatives and hypnotics; anxiolytics; opioids; central nervous system stimulants such as cocaine, amphetamines, and similarly acting sympathomimetics; hallucinogens; phencyclidine or similarly acting arylcyclohexylamines; cannabis; inhalants; and other psychoactive drugs and chemicals; and

(ii) ''Substance dependence'' means a condition in which a person is dependent on a substance, other than tobacco or ordinary xanthine-containing (e.g., caffeine) beverages, as evidenced by—

(A) Increased tolerance;

(B) Manifestation of withdrawal symptoms;

(C) Impaired control of use; or

(D) Continued use despite damage to physical health or impairment of social, personal, or occupational functioning.

(b) No substance abuse within the preceding 2 years defined as:

(1) Use of a substance in a situation in which that use was physically hazardous, if there has been at any other time an instance of the use of a substance also in a situation in which that use was physically hazardous;

(2) A verified positive drug test result acquired under an anti-drug program or internal program of the U.S. Department of Transportation or any other Administration within the U.S. Department of Transportation; or

(3) Misuse of a substance that the Federal Air Surgeon, based on case history and appropriate, qualified medical judgment relating to the substance involved, finds—

(i) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(ii) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

(c) No other personality disorder, neurosis, or other mental condition that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.109 Neurologic.

Neurologic standards for a first-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of any of the following:

(1) Epilepsy;

(2) A disturbance of consciousness without satisfactory medical explanation of the cause; or

(3) A transient loss of control of nervous system function(s) without satisfactory medical explanation of the cause.

(b) No other seizure disorder, disturbance of consciousness, or neurologic condition that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.111 Cardiovascular.

Cardiovascular standards for a first-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of any of the following:

(1) Myocardial infarction;

(2) Angina pectoris;

(3) Coronary heart disease that has required treatment or, if untreated, that has been symptomatic or clinically significant;

(4) Cardiac valve replacement;

(5) Permanent cardiac pacemaker implantation; or

(6) Heart replacement;

(b) A person applying for first-class medical certification must demonstrate an absence of myocardial infarction and other clinically significant abnormality on electrocardiographic examination:

(1) At the first application after reaching the 35th birthday; and

(2) On an annual basis after reaching the 40th birthday.

(c) An electrocardiogram will satisfy a requirement of paragraph (b) of this section if it is dated no earlier than 60 days before the date of the application it is to accompany and was performed and transmitted according to acceptable standards and techniques.

§ 67.113 General medical condition.

The general medical standards for a first-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of diabetes mellitus that requires insulin or any other hypoglycemic drug for control.

(b) No other organic, functional, or structural disease, defect, or limitation that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

(c) No medication or other treatment that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the medication or other treatment involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.115 Discretionary issuance.

A person who does not meet the provisions of §§ 67.103 through 67.113 may apply for the discretionary issuance of a certificate under § 67.401.

Subpart C—Second-Class Airman Medical Certificate

§ 67.201 Eligibility.

To be eligible for a second-class airman medical certificate, and to remain eligible for a second-class airman medical certificate, a person must meet the requirements of this subpart.

§ 67.203 Eye.

Eye standards for a second-class airman medical certificate are:

(a) Distant visual acuity of 20/20 or better in each eye separately, with or without corrective lenses. If corrective lenses (spectacles or contact lenses) are necessary for 20/20 vision, the person may be eligible only on the condition that corrective lenses are worn while exercising the privileges of an airman certificate.

(b) Near vision of 20/40 or better, Snellen equivalent, at 16 inches in each eye separately, with or without corrective lenses. If age 50 or older, near vision of 20/40 or better, Snellen equivalent, at both 16 inches and 32 inches in each eye separately, with or without corrective lenses.

(c) Ability to perceive those colors necessary for the safe performance of airman duties.

(d) Normal fields of vision.

(e) No acute or chronic pathological condition of either eye or adnexa that interferes with the proper function of an eye, that may reasonably be expected to progress to that degree, or that may reasonably be expected to be aggravated by flying.

(f) Bifoveal fixation and vergence-phoria relationship sufficient to prevent a break in fusion under conditions that may reasonably be expected to occur in performing airman duties. Tests for the factors named in this paragraph are not required except for persons found to have more than 1 prism diopter of hyperphoria, 6 prism diopters of esophoria, or 6 prism diopters of exophoria. If any of these values are exceeded, the Federal Air Surgeon may require the person to be examined by a qualified eye specialist to determine if there is bifoveal fixation and an adequate vergence-phoria relationship. However, if otherwise eligible, the person is issued a medical certificate pending the results of the examination.

§ 67.205 Ear, nose, throat, and equilibrium.

Ear, nose, throat, and equilibrium standards for a second-class airman medical certificate are:

(a) The person shall demonstrate acceptable hearing by at least one of the following tests:

(1) Demonstrate an ability to hear an average conversational voice in a quiet room, using both ears, at a distance of 6 feet from the examiner, with the back turned to the examiner.

(2) Demonstrate an acceptable understanding of speech as determined by audiometric speech discrimination testing to a score of at least 70 percent obtained in one ear or in a sound field environment.

(3) Provide acceptable results of pure tone audiometric testing of unaided hearing acuity according to the following table of worst acceptable thresholds, using the calibration standards of the American National Standards Institute, 1969:

Frequency (Hz)	500 Hz	1000 Hz	2000 Hz	3000 Hz
Better ear (Db)	35	30	30	40
Poorer ear (Db)	35	50	50	60

(b) No disease or condition of the middle or internal ear, nose, oral cavity, pharynx, or larynx that—

(1) Interferes with, or is aggravated by, flying or may reasonably be expected to do so; or

(2) Interferes with, or may reasonably be expected to interfere with, clear and effective speech communication.

(c) No disease or condition manifested by, or that may reasonably be expected to be manifested by, vertigo or a disturbance of equilibrium.

§ 67.207 Mental.

Mental standards for a second-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of any of the following:

(1) A personality disorder that is severe enough to have repeatedly manifested itself by overt acts.

(2) A psychosis. As used in this section, ''psychosis'' refers to a mental disorder in which:

(i) The individual has manifested delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition; or

(ii) The individual may reasonably be expected to manifest delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition.

(3) A bipolar disorder.

(4) Substance dependence, except where there is established clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including sustained total abstinence from the substance(s) for not less than the preceding 2 years. As used in this section—

(i) ''Substance'' includes: Alcohol; other sedatives and hypnotics; anxiolytics; opioids; central nervous system stimulants such as cocaine, amphetamines, and similarly acting sympathomimetics; hallucinogens; phencyclidine or similarly acting arylcyclohexylamines; cannabis; inhalants; and other psychoactive drugs and chemicals; and

(ii) ''Substance dependence'' means a condition in which a person is dependent on a substance, other than tobacco or ordinary xanthine-containing (e.g., caffeine) beverages, as evidenced by—

(A) Increased tolerance;

(B) Manifestation of withdrawal symptoms;

(C) Impaired control of use; or

(D) Continued use despite damage to physical health or impairment of social, personal, or occupational functioning.

(b) No substance abuse within the preceding 2 years defined as:

(1) Use of a substance in a situation in which that use was physically hazardous, if there has been at any other time an instance of the use of a substance also in a situation in which that use was physically hazardous;

(2) A verified positive drug test result acquired under an anti-drug program or internal program of the U.S. Department of Transportation or any other Administration within the U.S. Department of Transportation; or

(3) Misuse of a substance that the Federal Air Surgeon, based on case history and appropriate, qualified medical judgment relating to the substance involved, finds—

(i) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(ii) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

(c) No other personality disorder, neurosis, or other mental condition that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.209 Neurologic.

Neurologic standards for a second-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of any of the following:

(1) Epilepsy;

(2) A disturbance of consciousness without satisfactory medical explanation of the cause; or

(3) A transient loss of control of nervous system function(s) without satisfactory medical explanation of the cause;

(b) No other seizure disorder, disturbance of consciousness, or neurologic condition that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.211 Cardiovascular.

Cardiovascular standards for a second-class medical certificate are no established medical history or clinical diagnosis of any of the following:

(a) Myocardial infarction;

(b) Angina pectoris;

(c) Coronary heart disease that has required treatment or, if untreated, that has been symptomatic or clinically significant;

(d) Cardiac valve replacement;

(e) Permanent cardiac pacemaker implantation; or

(f) Heart replacement.

§ 67.213 General medical condition.

The general medical standards for a second-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of diabetes mellitus that requires insulin or any other hypoglycemic drug for control.

(b) No other organic, functional, or structural disease, defect, or limitation that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

(c) No medication or other treatment that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the medication or other treatment involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.215 Discretionary issuance.

A person who does not meet the provisions of §§ 67.203 through 67.213 may apply for the discretionary issuance of a certificate under § 67.401.

Subpart D—Third-Class Airman Medical Certificate

§ 67.301 Eligibility.

To be eligible for a third-class airman medical certificate, or to remain eligible for a third-class airman medical certificate, a person must meet the requirements of this subpart.

§ 67.303 Eye.

Eye standards for a third-class airman medical certificate are:

(a) Distant visual acuity of 20/40 or better in each eye separately, with or without corrective lenses. If corrective lenses (spectacles or contact lenses) are necessary for 20/40 vision, the person may be eligible only on the condition that corrective lenses are worn while exercising the privileges of an airman certificate.

(b) Near vision of 20/40 or better, Snellen equivalent, at 16 inches in each eye separately, with or without corrective lenses.

(c) Ability to perceive those colors necessary for the safe performance of airman duties.

(d) No acute or chronic pathological condition of either eye or adnexa that interferes with the proper function of an eye, that may reasonably be expected to progress to that degree, or that may reasonably be expected to be aggravated by flying.

§ 67.305 Ear, nose, throat, and equilibrium.

Ear, nose, throat, and equilibrium standards for a third-class airman medical certificate are:

(a) The person shall demonstrate acceptable hearing by at least one of the following tests:

(1) Demonstrate an ability to hear an average conversational voice in a quiet room, using both ears, at a distance of 6 feet from the examiner, with the back turned to the examiner.

(2) Demonstrate an acceptable understanding of speech as determined by audiometric speech discrimination testing to a score of at least 70 percent obtained in one ear or in a sound field environment.

(3) Provide acceptable results of pure tone audiometric testing of unaided hearing acuity according to the following table of worst acceptable thresholds, using the calibration standards of the American National Standards Institute, 1969:

Frequency (Hz)	500 Hz	1000 Hz	2000 Hz	3000 Hz
Better ear (Db)	35	30	30	40
Poorer ear (Db)	35	50	50	60

(b) No disease or condition of the middle or internal ear, nose, oral cavity, pharynx, or larynx that—

(1) Interferes with, or is aggravated by, flying or may reasonably be expected to do so; or

(2) Interferes with clear and effective speech communication.

(c) No disease or condition manifested by, or that may reasonably be expected to be manifested by, vertigo or a disturbance of equilibrium.

§ 67.307 Mental.

Mental standards for a third-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of any of the following:

(1) A personality disorder that is severe enough to have repeatedly manifested itself by overt acts.

(2) A psychosis. As used in this section, ''psychosis'' refers to a mental disorder in which—

(i) The individual has manifested delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition; or

(ii) The individual may reasonably be expected to manifest delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition.

(3) A bipolar disorder.

(4) Substance dependence, except where there is established clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including sustained total abstinence from the substance(s) for not less than the preceding 2 years. As used in this section—

(i) ''Substance'' includes: Alcohol; other sedatives and hypnotics; anxiolytics; opioids; central nervous system stimulants such as cocaine, amphetamines, and similarly acting sympathomimetics; hallucinogens; phencyclidine or similarly acting arylcyclohexylamines; cannabis; inhalants; and other psychoactive drugs and chemicals; and

(ii) ''Substance dependence'' means a condition in which a person is dependent on a substance, other than tobacco or ordinary xanthine-containing (e.g., caffeine) beverages, as evidenced by—

(A) Increased tolerance;

(B) Manifestation of withdrawal symptoms;

(C) Impaired control of use; or

(D) Continued use despite damage to physical health or impairment of social, personal, or occupational functioning.

(b) No substance abuse within the preceding 2 years defined as:

(1) Use of a substance in a situation in which that use was physically hazardous, if there has been at any other time an instance of the use of a substance also in a situation in which that use was physically hazardous;

(2) A verified positive drug test result conducted under an anti-drug rule or internal program of the U.S. Department of Transportation or any other Administration within the U.S. Department of Transportation; or

(3) Misuse of a substance that the Federal Air Surgeon, based on case history and appropriate, qualified medical judgment relating to the substance involved, finds—

(i) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(ii) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

(c) No other personality disorder, neurosis, or other mental condition that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.309 Neurologic.

Neurologic standards for a third-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of any of the following:

(1) Epilepsy;

(2) A disturbance of consciousness without satisfactory medical explanation of the cause; or

(3) A transient loss of control of nervous system function(s) without satisfactory medical explanation of the cause.

(b) No other seizure disorder, disturbance of consciousness, or neurologic condition that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.311 Cardiovascular.

Cardiovascular standards for a third-class airman medical certificate are no established medical history or clinical diagnosis of any of the following:

(a) Myocardial infarction;

(b) Angina pectoris;

(c) Coronary heart disease that has required treatment or, if untreated, that has been symptomatic or clinically significant;

(d) Cardiac valve replacement;

(e) Permanent cardiac pacemaker implantation; or

(f) Heart replacement.

§ 67.313 General medical condition.

The general medical standards for a third-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of diabetes mellitus that requires insulin or any other hypoglycemic drug for control.

(b) No other organic, functional, or structural disease, defect, or limitation that the Federal Air Surgeon, based on the case history and appropriate,

qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

(c) No medication or other treatment that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the medication or other treatment involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.315 Discretionary issuance.

A person who does not meet the provisions of §§ 67.303 through 67.313 may apply for the discretionary issuance of a certificate under § 67.401.

Subpart E—Certification Procedures

§ 67.401 Special issuance of medical certificates.

(a) At the discretion of the Federal Air Surgeon, an Authorization for Special Issuance of a Medical Certificate (Authorization), valid for a specified period, may be granted to a person who does not meet the provisions of subparts B, C, or D of this part if the person shows to the satisfaction of the Federal Air Surgeon that the duties authorized by the class of medical certificate applied for can be performed without endangering public safety during the period in which the Authorization would be in force. The Federal Air Surgeon may authorize a special medical flight test, practical test, or medical evaluation for this purpose. A medical certificate of the appropriate class may be issued to a person who does not meet the provisions of subparts B, C, or D of this part if that person possesses a valid Authorization and is otherwise eligible. An airman medical certificate issued in accordance with this section shall expire no later than the end of the validity period or upon the withdrawal of the Authorization upon which it is based. At the end of its specified validity period, for grant of a new Authorization, the person must again show to the satisfaction of the Federal Air Surgeon that the duties authorized by the class of medical certificate applied for can be performed without endangering public safety during the period in which the Authorization would be in force.

(b) At the discretion of the Federal Air Surgeon, a Statement of Demonstrated Ability (SODA) may be granted, instead of an Authorization, to a person whose disqualifying condition is static or nonprogressive and who has been found capable of performing airman duties without endangering public safety. A SODA does not expire and authorizes a designated aviation medical examiner to issue a medical certificate of a specified class if the examiner finds that the condition described on its face has not adversely changed.

(c) In granting an Authorization or SODA, the Federal Air Surgeon may consider the person's operational experience and any medical facts that may affect the ability of the person to perform airman duties including—

(1) The combined effect on the person of failure to meet more than one requirement of this part; and

(2) The prognosis derived from professional consideration of all available information regarding the person.

(d) In granting an Authorization or SODA under this section, the Federal Air Surgeon specifies the class of medical certificate authorized to be issued and may do any or all of the following:

(1) Limit the duration of an Authorization;

(2) Condition the granting of a new Authorization on the results of subsequent medical tests, examinations, or evaluations;

(3) State on the Authorization or SODA, and any medical certificate based upon it, any operational limitation needed for safety; or

(4) Condition the continued effect of an Authorization or SODA, and any second- or third-class medical certificate based upon it, on compliance with a statement of functional limitations issued to the person in coordination with the Director of Flight Standards or the Director's designee.

(e) In determining whether an Authorization or SODA should be granted to an applicant for a third-class medical certificate, the Federal Air Surgeon considers the freedom of an airman, exercising the privileges of a private pilot certificate, to accept reasonable risks to his or her person and property that are not acceptable in the exercise of commercial or airline transport pilot privileges, and, at the same time, considers the need to protect the safety of persons and property in other aircraft and on the ground.

(f) An Authorization or SODA granted under the provisions of this section to a person who does not meet the applicable provisions of subparts B, C, or D of this part may be withdrawn, at the discretion of the Federal Air Surgeon, at any time if—

(1) There is adverse change in the holder's medical condition;

(2) The holder fails to comply with a statement of functional limitations or operational limitations

issued as a condition of certification under this section;

(3) Public safety would be endangered by the holder's exercise of airman privileges;

(4) The holder fails to provide medical information reasonably needed by the Federal Air Surgeon for certification under this section; or

(5) The holder makes or causes to be made a statement or entry that is the basis for withdrawal of an Authorization or SODA under § 67.403.

(g) A person who has been granted an Authorization or SODA under this section based on a special medical flight or practical test need not take the test again during later physical examinations unless the Federal Air Surgeon determines or has reason to believe that the physical deficiency has or may have degraded to a degree to require another special medical flight test or practical test.

(h) The authority of the Federal Air Surgeon under this section is also exercised by the Manager, Aeromedical Certification Division, and each Regional Flight Surgeon.

(i) If an Authorization or SODA is withdrawn under paragraph (f) of this section the following procedures apply:

(1) The holder of the Authorization or SODA will be served a letter of withdrawal, stating the reason for the action;

(2) By not later than 60 days after the service of the letter of withdrawal, the holder of the Authorization or SODA may request, in writing, that the Federal Air Surgeon provide for review of the decision to withdraw. The request for review may be accompanied by supporting medical evidence;

(3) Within 60 days of receipt of a request for review, a written final decision either affirming or reversing the decision to withdraw will be issued; and

(4) A medical certificate rendered invalid pursuant to a withdrawal, in accordance with paragraph (a) of this section, shall be surrendered to the Administrator upon request.

(j) No grant of a special issuance made prior to September 16, 1996, may be used to obtain a medical certificate after the earlier of the following dates:

(1) September 16, 1997; or

(2) The date on which the holder of such special issuance is required to provide additional information to the FAA as a condition for continued medical certification.

§ 67.403 Applications, certificates, logbooks, reports, and records: Falsification, reproduction, or alteration; incorrect statements.

(a) No person may make or cause to be made—

(1) A fraudulent or intentionally false statement on any application for a medical certificate or on a request for any Authorization for Special Issuance of a Medical Certificate (Authorization) or Statement of Demonstrated Ability (SODA) under this part;

(2) A fraudulent or intentionally false entry in any logbook, record, or report that is kept, made, or used, to show compliance with any requirement for any medical certificate or for any Authorization or SODA under this part;

(3) A reproduction, for fraudulent purposes, of any medical certificate under this part; or

(4) An alteration of any medical certificate under this part.

(b) The commission by any person of an act prohibited under paragraph (a) of this section is a basis for—

(1) Suspending or revoking all airman, ground instructor, and medical certificates and ratings held by that person;

(2) Withdrawing all Authorizations or SODA's held by that person; and

(3) Denying all applications for medical certification and requests for Authorizations or SODA's.

(c) The following may serve as a basis for suspending or revoking a medical certificate; withdrawing an Authorization or SODA; or denying an application for a medical certificate or request for an authorization or SODA:

(1) An incorrect statement, upon which the FAA relied, made in support of an application for a medical certificate or request for an Authorization or SODA.

(2) An incorrect entry, upon which the FAA relied, made in any logbook, record, or report that is kept, made, or used to show compliance with any requirement for a medical certificate or an Authorization or SODA.

§ 67.405 Medical examinations: Who may give.

(a) *First-class.* Any aviation medical examiner who is specifically designated for the purpose may give the examination for the first-class medical certificate. Any interested person may obtain a list of these aviation medical examiners, in any area,

from the FAA Regional Flight Surgeon of the region in which the area is located.

(b) *Second- and third-class.* Any aviation medical examiner may give the examination for the second- or third-class medical certificate. Any interested person may obtain a list of aviation medical examiners, in any area, from the FAA Regional Flight Surgeon of the region in which the area is located.

§ 67.407 Delegation of authority.

(a) The authority of the Administrator under 49 U.S.C. 44703 to issue or deny medical certificates is delegated to the Federal Air Surgeon to the extent necessary to—

(1) Examine applicants for and holders of medical certificates to determine whether they meet applicable medical standards; and

(2) Issue, renew, and deny medical certificates, and issue, renew, deny, and withdraw Authorizations for Special Issuance of a Medical Certificate and Statements of Demonstrated Ability to a person based upon meeting or failing to meet applicable medical standards.

(b) Subject to limitations in this chapter, the delegated functions of the Federal Air Surgeon to examine applicants for and holders of medical certificates for compliance with applicable medical standards and to issue, renew, and deny medical certificates are also delegated to aviation medical examiners and to authorized representatives of the Federal Air Surgeon within the FAA.

(c) The authority of the Administrator under 49 U.S.C. 44702, to reconsider the action of an aviation medical examiner is delegated to the Federal Air Surgeon; the Manager, Aeromedical Certification Division; and each Regional Flight Surgeon. Where the person does not meet the standards of §§ 67.107(b)(3) and (c), 67.109(b), 67.113(b) and (c), 67.207(b)(3) and (c), 67.209(b), 67.213(b) and (c), 67.307(b)(3) and (c), 67.309(b), or 67.313(b) and (c), any action taken under this paragraph other than by the Federal Air Surgeon is subject to reconsideration by the Federal Air Surgeon. A certificate issued by an aviation medical examiner is considered to be affirmed as issued unless an FAA official named in this paragraph (authorized official) reverses that issuance within 60 days after the date of issuance. However, if within 60 days after the date of issuance an authorized official requests the certificate holder to submit additional medical information, an authorized official may reverse the issuance within 60 days after receipt of the requested information.

(d) The authority of the Administrator under 49 U.S.C. 44709 to re-examine any civil airman to the extent necessary to determine an airman's qualification to continue to hold an airman medical certificate, is delegated to the Federal Air Surgeon and his or her authorized representatives within the FAA.

§ 67.409 Denial of medical certificate.

(a) Any person who is denied a medical certificate by an aviation medical examiner may, within 30 days after the date of the denial, apply in writing and in duplicate to the Federal Air Surgeon, Attention: Manager, Aeromedical Certification Division (AAM–300), Federal Aviation Administration, P.O. Box 26080, Oklahoma City, Oklahoma 73126, for reconsideration of that denial. If the person does not ask for reconsideration during the 30-day period after the date of the denial, he or she is considered to have withdrawn the application for a medical certificate.

(b) The denial of a medical certificate—

(1) By an aviation medical examiner is not a denial by the Administrator under 49 U.S.C. 44703.

(2) By the Federal Air Surgeon is considered to be a denial by the Administrator under 49 U.S.C. 44703.

(3) By the Manager, Aeromedical Certification Division, or a Regional Flight Surgeon is considered to be a denial by the Administrator under 49 U.S.C. 44703 except where the person does not meet the standards of §§ 67.107(b)(3) and (c), 67.109(b), or 67.113(b) and (c); 67.207(b)(3) and (c), 67.209(b), or 67.213(b) and (c); or 67.307(b)(3) and (c), 67.309(b), or 67.313(b) and (c).

(c) Any action taken under § 67.407(c) that wholly or partly reverses the issue of a medical certificate by an aviation medical examiner is the denial of a medical certificate under paragraph (b) of this section.

(d) If the issue of a medical certificate is wholly or partly reversed by the Federal Air Surgeon; the Manager, Aeromedical Certification Division; or a Regional Flight Surgeon, the person holding that certificate shall surrender it, upon request of the FAA.

§ 67.411 Medical certificates by flight surgeons of Armed Forces.

(a) The FAA has designated flight surgeons of the Armed Forces on specified military posts, stations, and facilities, as aviation medical examiners.

(b) An aviation medical examiner described in paragraph (a) of this section may give physical examinations for the FAA medical certificates to persons who are on active duty or who are, under Department of Defense medical programs, eligible for FAA medical certification as civil airmen. In addition, such an examiner may issue or deny an appropriate FAA medical certificate in accordance with the regulations of this chapter and the policies of the FAA.

(c) Any interested person may obtain a list of the military posts, stations, and facilities at which a flight surgeon has been designated as an aviation medical examiner from the Surgeon General of the Armed Force concerned or from the Manager, Aeromedical Education Division (AAM–400), Federal Aviation Administration, P.O. Box 26082, Oklahoma City, Oklahoma 73125.

§ 67.413 Medical records.

(a) Whenever the Administrator finds that additional medical information or history is necessary to determine whether an applicant for or the holder of a medical certificate meets the medical standards for it, the Administrator requests that person to furnish that information or to authorize any clinic, hospital, physician, or other person to release to the Administrator all available information or records concerning that history. If the applicant or holder fails to provide the requested medical information or history or to authorize the release so requested, the Administrator may suspend, modify, or revoke all medical certificates the airman holds or may, in the case of an applicant, deny the application for an airman medical certificate.

(b) If an airman medical certificate is suspended or modified under paragraph (a) of this section, that suspension or modification remains in effect until the requested information, history, or authorization is provided to the FAA and until the Federal Air Surgeon determines whether the person meets the medical standards under this part.

§ 67.415 Return of medical certificate after suspension or revocation.

The holder of any medical certificate issued under this part that is suspended or revoked shall, upon the Administrator's request, return it to the Administrator.